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THE LIABILITY OF DOCTORS AND HOSPITALS IN CANADA

by



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A THESIS

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ABSTRACT

The research that culminated in this thesis was begun because of my involvement in teaching law to health care professionals. I found that there was a dearth of Canadian publication on the topic of health law. Thus, it was difficult to find out what the law was, and any analysis of its implications was rare.

My goal was to find the Canadian law relevant to the civil liability of physicians, dentists, nurses and hospitals and to set it out as clearly as possible. Aware of the interests and needs of judges, lawyers, health care professionals and administrators in this area of the law, I attempted throughout to do an analysis of the law so that its strengths and weaknesses would be more apparent. Hopefully, decision-making by all concerned will be assisted by this review.

In setting out the Canadian law and reviewing it, I looked to the law of other jurisdictions where relevant or helpful and especially to England, the source of much of our law, and to the United States, the source of much concern about the effect of law on health care.

Finally, I have briefly discussed two common concerns: first that we will suffer a "malpractice crisis" in Canada similar to that suffered in the United States, and second that civil litigation is no longer a practical process for the patient seeking compensation. I have also made some suggestions for the future.

In summary, the purpose of this thesis is to provide a statement of Canadian law on the civil liability of health care professionals and hospitals and a commentary upon it.

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CHAPTER I

THE CONDUCT OF A CIVIL ACTION

1. Introduction

The legal system occupies a unique place among our society's institutions: there is none other which influences our lives so directly and yet about which public knowledge is so limited.¹ Thus, a brief explanation of the system is necessary. The purpose of this chapter is to explain to the non-legal reader some of the legal terminology and procedure with which he may be unfamiliar. This knowledge will aid in the understanding of the material to follow.

2. The Canadian Legal System

(a) Sources of Law: Stare Decisis

The primary source of law, the body of rules which governs the behaviour of members of society, is statute law, or legislation - an act of the Parliament of Canada or of a Provincial Legislature. The significance of legislation has risen dramatically in modern times, and as society grows in size and complexity this trend is likely to continue.

1. For a general discussion of the Canadian legal system see Gall, The Canadian Legal System (1977).

The division of legislative power between the Federal and Provincial governments is made according to sections 91 and 92 of the British North America Act.² Health and medical care is not dealt with specifically by the Act, but "general legislative competence over health and welfare services, however, has been taken to reside at the provincial level."³ This explains why the law with respect to some health matters varies from province to province.

However, the Federal government has the right to place conditions on the disbursements of funds it makes to the provinces.⁴ This is referred to as "spending power" and it is with this that the Federal government's role in health and welfare services is generally associated.⁵ A good examples of this is Medicare. Although the Federal government has no right to compel a province to administer its medical insurance program in any particular manner, it can, and did, so demand in exchange for payments to help support the scheme.

Not all problems in society are covered by legislation, however, and in the absence of a statute, judge and lawyers refer to the case law, or the common law.

This is the body of principles which have emerged from the written judgments of actual court cases, and is the chief component by which

2. 1867 (30 & 31 Vict., c.3).

3. Lyon and Atkey, eds., Canadian Constitutional Law in a Modern Perspective 789 (1970).

4. C.M.H.C. v. Co-op. College Residences Inc. (1975) 71 D.L.R. (3d) 183 at 200 (Ont. C.A.).

5. Supra n. 3.

our legal system is distinguished from those employed elsewhere. For historical reasons, Quebec uses a different system,⁶ one similar to those used in Continental Europe, but all other provinces in Canada are common law jurisdictions.

In his judgment of a case, a judge will generally set out, among other things, the legally significant factors of the dispute, the results of law which are brought into operation by those factors, and the reasoning he used to reach a final decision in the case. The combination of these three elements is referred to generally as the reasons for decision, or ratio decidendi of the case. The judges and lawyers who interpret the case in the future usually articulate the ratio into a statement to the effect that when fact situation "X" occurs, legal result "Y" will be the outcome. Each one of these statements or principles is called a legal precedent. Several legal precedents on various points of law may spring from one case. The formation of these precedents and their subsequent interpretation and application in other cases form the web of the case law structure. They provide the law with predictability and yet are sufficiently flexible to allow change to be made.

In addition to those things comprising the ratio decidendi a judge will usually have a great deal more to say in the course of delivering his judgment. Any statements in his judgment which do not form part of the ratio are called collectively obiter dicta, often referred to as simply obiter or dicta. These are often important and helpful as indi-

6. A more detailed discussion of the system in use in Quebec appears later in this chapter.

cations of what the result might be when a fact situation slightly different from that before the court arises before another court at a later date.

The common law system is based on the principle that similar fact situations should yield similar legal results. This means that a judge must look to the legal precedents or ratios of earlier cases for guidance in coming to a decision on the matter before him. This principle is referred to as stare decisis which translates literally as "to stand by decided matters".⁷ Sometimes a judge might feel that the application of the existing ratio to the case before him would lead to an unjust result. In such situations he may "overrule" the principle, that is, he will not apply it and may go on to state that it is no longer the appropriate rule to be applied in cases of the type being decided. But the more common practice is to "distinguish" the precedent. When a judge distinguishes a case, he refuses to apply the principle that seems to be relevant, not because he wishes to overrule it, but because he believes the case before him has features which remove it from the scope of the rule.

In this thesis our concern is with the application of the principle of stare decisis at only three levels of the Canadian hierarchy of courts: the supreme trial courts and the courts of appeal of all the Provinces, and the Supreme Court of Canada. Decisions given in the Supreme Court of Canada are binding on all courts in Canada,⁸ and

7. Gall, supra n. 1 at 180.

8. Because of the difference in legal systems, in some cases a decision of the Supreme Court of Canada on a case originating in Quebec may not be binding in a common law province.

within each province the court of appeal binds all lower courts within the province. Decisions from other provinces other than that of the court rendering a decision are not binding on that court but nevertheless would be considered. High level decisions from other jurisdictions, for example, the House of Lords in England or the upper courts in Australia or New Zealand are not binding on any Canadian court but are extremely persuasive authority. Similarly, obiter dicta from any source, even Canadian, is not binding, but if it is from a high level court it may have persuasive value.

Decisions from American courts are rarely cited for authority in Canada. But while they are neither binding or even persuasive to a Canadian court they are sometimes helpful when decisions are required on matters which have not yet come before our courts, but have been decided in the United States. Their search for solutions to some of these problems can sometimes suggest a logical resolution to the difficulty or indicate a pitfall to be avoided. However, caution must always be exercised when referring to American law because of the great differences between our two legal systems.

(b) The Legal System of Quebec

(i) The common law and the civil law systems

While the common law and the civil law systems are similar in some respects, their approaches to the law are fundamentally different.⁹

⁹ Gall, supra n. 1 at 39.

We have seen that under the common law system, rules of law are generalized from the decisions of particular cases. The civil law system is the reverse of this process; cases are decided according to an accepted set of principles codified in the Civil Code.¹⁰ For this reason courts in civil law systems are not bound, in theory at least, by the doctrine of stare decisis, hence a judge in the civil law system can apply the Code to suit the dictates of justice and be less concerned than his common law counterpart about departures from traditional interpretations of the Code, or about setting a "bad precedent".¹¹ However, while the Code and common law have different reasoning and techniques, both offer identical results in the medical law areas.¹²

(ii) Sources of Law

If the Code is clear and relevant to the matter at hand it must be applied.¹³ In cases where matters are less clear, a civil law judge may make reference to the following to aid him in his decisions:

- (a) other articles in the Civil Code
- (b) The reports of the Commissioners,
- (c) la doctrine

10. Id.

11. Id. at 40.

12. See Crepeau, Kirkland-Casgrain, The Quebec Civil Code in Contemporary Issues in Canadian Law for Nurses 15 at 17 (1973).

13. Castel, The Civil Law System of the Province of Quebec 187 at 218, 234 (1962). See also Mignault, The Authority of Decided Cases (1925) 3 Can. Bar Rev. 1.

(d) la jurisprudence.

The spirit of the Code is that it is an organic whole, and so other articles in the Code will be consulted to see if they give indications of how the particular article is to be applied.

It is the task of the Commissioners to research the law and to bring about reform of the Code in the form of amendments and additions. Their reports indicate the source of a particular article, the state of law prior to its enactment, and their intentions and goals in bringing about the various amendments and additions. When an article has been derived from French law, French authorities may be considered; if there is similarity with English law, then English authorities may be consulted. However, these aids are for guidance only and are not to be made part of the Code.¹⁴

If, after referring to the Code and consulting the Commissioner's reports, the Court requires further assistance, it will consider la doctrine and then la jurisprudence. La doctrine is the name applied to the legal writings of judges, practicing lawyers and law professors. The work of the academics enjoys no such status in the common law system, and even in Quebec, there are not enough authors to provide a foundation of written legal opinion sufficient to make la doctrine a major source of law.¹⁵

14. Walton, The Scope and Interpretation of the Civil Code of Lower Canada (1907). Note that as in the common law provinces reports of debates of provincial legislature cannot be consulted. See Castel, id. at 162.

15. Tanguay v. Can. Elec. Light Co. (1908) 40 S.C.R. 1 at 34 per Girouard J.

The lack of Quebec doctrine is one reason that la jurisprudence, the case law, is more important there than in other civil law jurisdictions. Although much has been written about whether the doctrine of stare decisis has been adopted in Quebec,¹⁶ the best opinion appears to be that it has not, even if the decision in question is from the Supreme Court of Canada.¹⁷ However this theroretical freedom is tempered by conservatism and common sense; la jurisprudence will be heard with respect and found persuasive if the reasoning is sound.

(c) Types of Legal Action

Three types of legal action most commonly involve doctors: a disciplinary action brought by his professional association, a criminal action brought by the Crown, or a civil action brought by a patient. The last of these is the major topic of this thesis, and accordingly its attendant procedures will be emphasized in this chapter. However, some remarks with respect to the first two ought to be made at this point.

The disciplinary action is commenced by the professional association against a doctor who has breached the standards of ethics or practice of the association. The case is not initiated within the court system but is held before various tribunals established for the

16. See Friedmann, Stare Decisis at Common Law and under the Civil Code of Quebec (1953) 31 Can. Bar Rev. 723; Walton, supra n. 14 at 109; Castel, supra n. 13 at 229.

17. Castel, supra n. 13 at 229.

purpose by the association. The penalties may range from a mere reprimand to a fine, suspension, or even permanent expulsion from the profession. The action is designed to enable the association to maintain consistent levels of competence. Rules have developed which ensure that a fair hearing will be given by the tribunal, and in the event that a doctor is dissatisfied with his treatment, recourse to the courts is generally available to determine the validity of the tribunal's ruling.

A criminal action is commenced by the Crown against those who violate the criminal law, and exists for the protection of society.

Examples of offences for which a doctor could be charged in the criminal proceedings would be causing another's death, if his conduct amounted to "criminal negligence" within the meaning of the Criminal Code,¹⁸ or performing an illegal abortion,¹⁹ both of which carry a maximum penalty of life imprisonment.²⁰

Before turning to the civil action, three points ought to be noted about the disciplinary and criminal actions. First, both of these are punitive in nature; they provide no compensation to a patient who has been injured by the wrongful act of a doctor. Second, they are both brought by an independent institution established to protect the public. Third, a single wrongful act of a doctor could conceivably result in the bringing of both of these actions as well as a civil

18. Criminal Code, R.S.C. 1970, c. C-34, s. 203. Such actions are extremely rare.

19. Id. s. 251(1).

20. Id. ss. 203, 251(1).

action by the patient. In contrast to the actions just discussed, the civil action is designed to compensate a person who has been harmed by the wrongful act of another and is initiated by the person harmed.

3. The Civil Action

Just as legal actions in general are classified as "disciplinary", "criminal", or "civil", the civil action itself is further classified. The label attached to a given civil action is determined by the nature of the legal wrong alleged to have been committed.²¹ However, regardless of the classification of the civil action, the procedure followed in bringing the action is essentially the same.

Our legal system utilizes a method of fact-finding called the adversary system. Under this system, the party to the action adopts a partisan viewpoint and does everything in his power and within legal restraints, to prove the facts as he alleges them to be, and at the same time, to disprove the facts as his opponent alleges them to be. Theoretically the strenuous promotion of both aspects of the conflict before an impartial judge or panel of lay persons (a jury) results in the truth's being found.

However, as pointed out by Mr. Justice Haines:²²

21. The types of civil actions are discussed generally infra Chapter 3.

22. Haines, The Medical Profession and the Adversary Process (1973) 11 O.H.L.J. 41 at 42.

Doctors do not take kindly to the adversary system. It is entirely foreign to their way of settling disputes. When they disagree on a diagnosis or treatment technique, they attempt to resolve it by obtaining the assistance of more experienced scientists and each joins in an objective search for the truth. It would be unthinkable for them to refer the matter to an independent layman, whether he be judge or jury. Even if they did, there are no specialist judges in malpractice matters and the majority, have no training in basic anatomy and physiology...the great bulk of bad results from medical care arise in a terribly grey area where the law may see negligence but medicine sees merely an unexpected occurrence in a very inexact art. Here we must recognize the difference in thinking between lawyers and doctors. The lawyer is armed with the most accurate diagnostic instrument, the "retroscope". With twenty-twenty vision he seizes on the unfortunate result, second-guesses the doctor and charges him with fault, although at the time of treatment the symptoms and the various tests presented a very foggy picture and resulted in a complex, differential diagnosis.

In addition to this, a doctor, when put on the witness stand in court as defendant or expert witness will find himself "...attacked by the other side on what he has heard, seen and remembered, and then for good measure, he may find his credibility questioned."²³

Realizing that our legal process is by tradition an adversarial one will facilitate a better understanding of "civil procedure", the name given to the series of procedural steps required to commence the action in the courts and bring it to completion. This section of the chapter describes the civil procedure of the provinces of Canada. All the procedures and the documents to be described are found in one form or another in all the provincial jurisdictions, including Quebec, there being only minor differences in detail and nomenclature among the provinces. The nomenclature used in this discussion is that of the civil procedure rules of the Province of Alberta.²⁴

23. Id.

24. See Alberta Supreme Court Rules, Alta. Reg. 390/68 (1968) as amended.

(a) The Complaint

The complaint is not a part of the formal procedure, but nevertheless is the starting point of most civil actions. The aggrieved patient or his lawyer contacts the doctor and makes an informal demand for compensation. Although the doctor may be of the opinion that he was at fault and that the claim is justified and may decide to pay the demand or a portion of it, he ought to be cautious about adopting this course of action. Most Canadian doctors belong to the Canadian Medical Protective Association and should consider the advice it gives to its members.²⁵

The doctor may refuse the demand altogether, and the patient might simply drop the matter. Nevertheless, the doctor should keep copies of any correspondence relating to the incident, or, if the demand was oral, compose a memo on the subject immediately, containing such details as the date of the demand, the injuries complained of, the misconduct alleged, the amount asked and his own statements to the patient. Should the patient then later change his mind and decide to proceed with the action,²⁶ the doctor will have a record of the earlier decision. If it is evident that the patient intends to pursue the matter then any further attempts by him or his solicitor to communicate with the doctor should be referred to the doctor's lawyer.

25. Canadian Medical Protective Association, Constitution and By-Laws (1973).

26. Under various provincial statutes, a person must start his action within a certain time period, called a limitation period; however, some of these periods are fairly long - up to six years, depending on the circumstances.

All provinces have limitation statutes which set out a time within which a doctor must be sued or the action will be barred. Because most provide that the limitation period starts to run from the time that professional services are terminated, the doctor might also consider terminating the doctor-patient relationship. If this course of action is taken, the adoption of safeguards against being sued for abandonment as well will of course be necessary.²⁷

The doctor will most likely be made aware of the patient's intention to continue his claim by the receipt of a formal document drafted by the patient's solicitor and issued through the court. This brings us to the first stage of formal civil procedure.

(b) Pre-Trial Procedures

The pre-trial procedures can be broken roughly into two categories: pleadings and discoveries. The former are a series of documents exchanged between the parties to the action which serve to clarify the issues in contention, while the latter give the parties an opportunity to obtain a "sneak preview" of each other's case before trial. In many cases, the information obtained through the pleadings and discovery stages of the litigation (as the formally commenced civil action is referred to) leads to an early settlement of the dispute, saving both parties the expense and inconvenience of a trial.

27. See infra Chapter 2.

The formal document sent by the patient (to whom we will now refer as the "plaintiff", the name given to the person who sues) and received by the doctor (to whom we will now refer as the "defendant", the name given to the person who is sued) is the first document in the pleadings and is called a Statement of Claim. It contains a statement of the facts leading to the dispute, as alleged by the plaintiff, the particulars of the legal wrong upon which his claim is based and a demand, called a "prayer", for a specific sum of money, called "damages".

In response to the Statement of Claim, the defendant's lawyer prepares a document called a Statement of Defence. It may contain an alternate version of the facts, where the defence is based on a difference in fact, or it may be only a simple denial of all the allegations made by the plaintiff in the Statement of Claim. There will also be a prayer that the action will be dismissed. This document must be filed with the court and served on the plaintiff within a short time of the service of the Statement of Claim on the defendant.²⁸ If this period is exceeded, the plaintiff may "note the defendant in default" and subsequently obtain a "default judgment", a formal entry on the court record that he is entitled to his compensation. For this reason it is crucial that a doctor in receipt of a Statement of Claim contact his lawyer immediately.

In most actions, numerous other documents appear among the pleadings. However, they are rarely seen by the doctor himself and need not

28. For example, 15 days in Alberta: Supreme Court Rules, supra n. 24, s. 85(1)(b).

be described in detail here. When all the necessary documents have been exchanged or filed with the court, or both, it is said that the pleadings are closed.

Following closure of the pleadings the discoveries will be held. There are generally two discoveries: the discovery of documents and the examination for discovery.

The discovery of documents gives each party the right to examine all the correspondence, charts, photographs, or "records of any kind"²⁹ that the other party has in his possession or control and which bear upon the litigation. The party whose documents are being "discovered" must prepare a list of all the relevant documents he has or can obtain and must swear an "affidavit" to the effect that the list is complete. It is vital that the list be actually complete: swearing a false affidavit amounts to perjury and carries a maximum prison term of 14 years.³⁰ This does not mean however that a party must release documents which for one reason or another are "privileged".³¹ Such documents he can object to producing and if a dispute arises over whether the objection is valid or not, a judge will rule on the matter.

The examination for discovery usually follows the discovery of documents. It is a meeting attended by the parties to the action, their counsel and a court reporter. Each party is questioned and answers are taken down in shorthand by a court report and are typed into a transcript.

29. Id. s. 186(1).

30. Criminal Code, supra n. 18, s. 122.

31. See infra Chapter 2.

At the examination for discovery counsel has much wider powers of questioning than are permitted at trial, and the party must generally answer any question that is relevant. Following the examination for discovery both lawyers receive a copy of the transcript and at the trial, each counsel may read into the trial record as part of the evidence to support his client's case, as many of the questions and answers as he wishes from his discovery of the opposing party. He cannot of course read in a segment whose meaning has been altered by its removal from context. The major advantage of the examination for discovery is that the parties learn much about the strengths and weaknesses of each other's case. It is for this reason that many law suits are settled after the discovery stage of the litigation.

(c) The Trial

The trial is the forum in which the plaintiff seeks to prove his case against the defendant. He must prove all the facts which give rise to the legal basis for liability, and then convince the court with legal argument that the precedents indicate that the factors proven support a finding of liability on the part of the defendant. Unless he is successful in doing all of this, the action will be dismissed; and in most actions, even if he is successful he must also prove to the court his damages, that is, the extent of his injuries, both physical and financial.

The trial is conducted on a witness-by-witness basis. The plaintiff, because he has the onus of proof, calls his witnesses first. After each witness is questioned in "examination-in-chief" by the

plaintiff's lawyer, he is then "cross-examined" by the defendant's lawyer. After all the plaintiff's witnesses have been heard, his documentary evidence placed before the court, and the desired portions of the transcript from the discovery read into the court record (that is, dictated by the plaintiff's counsel to the court reporter) the defendant then proceeds in a similar manner.

After all the evidence, verbal and documentary, has been placed before the court (usually, in medical liability cases in Canada, comprised of a judge alone rather than a jury) the judge will give his judgment. He may do so immediately, or "reserve judgment" and deliver it at a later date. When delivered, it will generally deal with both liability and damages.

It is important to distinguish between proof of liability and proof of damages. Proof of liability involves the court in an investigation of the question, "Who was at fault in causing the plaintiff's injuries?". Proof of damage involves only the question "Regardless of who, if anyone, is responsible for the injuries, what is the appropriate amount of money to compensate the plaintiff for his loss?".

In his Statement of Claim, the plaintiff will as a result have claimed two types of damages: special and general. Special damages are awarded to compensate for out-of-pocket expenses borne by the plaintiff up to the date of the trial and include such items as costs of medical care, loss of wages, cost of renting prosthetic equipment or hiring private nursing care. General damages are awarded to compensate for pain and suffering, loss of amenities of life, diminution of life expectancy and the like and are of course rather arbitrary in quantum.

Usually the amount of general damages claimed by the plaintiff is inflated and is substantially reduced by the trial judge.³²

In certain kinds of actions³³ where the defendant's behaviour is intentional and particularly reprehensible, punitive or exemplary damages may be claimed. They are in essence an imposition of a penalty upon the defendant in the form of extra damages to the plaintiff.

Even if the action is dismissed, the trial judge will usually assess the damages. This is done in case an appeal court disagrees with the trial judge and imposes liability on the defendant. Should this occur, the earlier assessment of the damages by the trial judge will save the parties the expense and inconvenience of re-litigating the issue.

At the end of his judgment the trial judge will also make an award of "costs", usually to the party who has been victorious in the action. This means that the party in whose favour costs have been awarded is entitled to collect from the other party a portion of his legal expenses, calculated accordingly to tables found in the rules of procedure in each jurisdiction.³⁴ Note that only a portion of the legal expenses incurred by a party are recoverable: not the total amount of his lawyer's fee.

32. In the case of special damages, the parties generally come to agreement on the amount prior to the trial.

33. See infra Chapter 3.

34. See, for example, Supreme Court Rules, supra n. 24, Schedule C.

(d) Post-Trial Procedures

Following the trial, the unsuccessful party has a short period of time from the date of formal entry of the judgment at the office of the Clerk of the Court to file a Notice of Appeal.³⁵ This is a document directed to the other party (called the respondent) informing him that the unsuccessful party (called the appellant) intends to appeal the decision of the trial judge to the court of appeal of the province. This initiates another series of procedures which need not be dealt with in detail here. The decision whether to appeal or not must be made in each case by the client with the advice of his lawyer.

Whichever party loses at the provincial court of appeal can apply to the Supreme Court of Canada to appeal the decision to that court. Under the Supreme Court Act³⁶ leave will be granted:³⁷

...where, with respect to the particular case sought to be appealed, the Supreme Court is of the opinion that any question involved therein is,...of such a nature or significance as to warrant decision by it....

If leave is granted, the litigants enter another procedure leading to the hearing of the case in the highest court in the land, the decision of which is final.

35. For example, 20 days in Alberta: Supreme Court Rules supra n. 24, s. 506.

36. R.S.C. 1970, c. S-19.

37. Id. s. 41(1)[re-en. 1974-75-76, c.18, s. 5].

This has been a brief summary of the legal systems and the civil procedures employed in Canada. Much detail has been omitted in the interests of providing those not familiar with the legal system with a basic understanding of its features.

CHAPTER II

THE DOCTOR-PATIENT RELATIONSHIP

1. Nature of the Relationship

(a) Historical Development

The legal relationship of doctor and patient has been described differently over the past six centuries.¹ Originally the medical profession, like that of apothecary, barbering and innkeeping, was a "common calling". This meant that when a doctor practised medicine a duty to his patient came into being. In order to protect the public, certain legal constraints were placed on the exercise of that duty. The doctor had to use proper care and skill² because the law required it.

Upon the development of the law contract, this original delictual³ basis for liability was superseded by a contractual

1. The first reported case against a doctor is dated 1374 and was an action against a surgeon. Morton's case (1374) 48 Edw. III f6 pl 11.

2. Holdsworth, 3 History of English Law 385-6; Everard v. Hopkins (1615) 2 Bulstrode 332, 80 E.R. 1164 (K.B.).

3. See Black's Law Dictionary 514 (4th ed. 1968). The term is "wider in both directions" than the term "tort" which is often used as a synonym.

one.⁴ The offer could be found in the patient's request for treatment and the acceptance in the doctor's commencement of care. Consideration was not a problem unless the patient was unable to pay. In such circumstances the law of contract was strained somewhat and it was held that the patient's submission to treatment was sufficient consideration for the doctor's services.⁵ Many terms of the contract were implied by law, as for example, that the doctor possessed and would use due care and skill⁶ and thus the most common contractual relationship could be described as one of an implied contract between doctor and patient. There may have been some doctors and patients who left nothing to be implied but set out the exact terms of their agreement in an express contract.

The past century and a half has been dominated by the tort of negligence. It is therefore not surprising that the liability of the doctor came to be judged by its principles.⁷ The "common calling" which gave birth to the concept of duty in the doctor-patient relationship contained within it the seed of the negligence action which sprang to life in the fertile environment of the Industrial Revolution.⁸

4. Holdsworth, supra n. 2 at 448; Cheshire and Fifoot, Law of Contract (8th ed. 1972); for the American expression of this see Leighton v. Sargent (1853) 27 N.H. 460, 59 Am. Dec. 388 (N.H.S.C.).

5. Coggs v. Bernard (1703) 2 Ld. Raym. 909, 92 E.R. 107 (K.B.); Banbury v. Bank of Montreal [1918] A.C. 626 at 657 (H.L.).

6. Slater v. Baker (1767) 2 Wils. K.B. 359, 95 E.R. 860.

7. See infra c. 5. Note that some patients may not have capacity to contract, e.g., psychiatric patients.

8. Fleming, The Law of Torts 102-3 (4th ed. 1971).

Thus, for nearly a century most actions against doctors have been based on negligence.⁹

During the transition periods when the characterization of the relationship changed from common calling to implied contract and finally to negligence there was confusion about the proper way to plead a case.¹⁰ Some judges were prepared to allow the plaintiff to recover damages if it seemed fair. They would not "look with eagle's eyes [at] the evidence" and preclude recovery because the case had a technical defect.¹¹ This was not as onerous as it might seem because the duty of a doctor to his patient was essentially the same whether found in the practice of a common calling, in the term of an implied contract, or as the fulfillment of the appropriate standard of care in the modern negligence action.¹²

The duty of care that is born as soon as a doctor undertakes the medical treatment of a patient has been fostered by the medical profession for centuries¹³ and is now held to exist independently of any contract between doctor and patient. There is a duty to use reasonable care, skill and judgment when a doctor attends to an unconscious

9. Edwards v. Mallan [1908] 1 K.B. 1002 (C.A.).

10. Everard v. Hopkins *supra* n. 2; Edwards v. Mallan *id.*

11. Slater v. Baker *supra* n. 6.

12. Roe v. Minister of Health; Woolley v. Same [1954] 1 W.L.R. 128 at 131; affirmed [1954] 2 Q.B. 66 (C.A.); Nathan, Medical Negligence 7 (1956).

13. Oath of Hippocrates *infra* at 25.

patient who cannot be held to have voluntarily submitted¹⁴ or when a third party is paying for the service.¹⁵ A doctor need not undertake the care of a patient but once he has done so he must exercise proper care and skill.¹⁶

The ancient and honourable profession of medicine nurtured the development of the doctor-patient relationship into one of trust and confidence. The law raised its expectations accordingly but has not always given protection in the courts to this trust since there is no privilege extended to the communications between doctor and patient.¹⁷ The doctor, like the lawyer but unlike the architect or engineer,¹⁸ is in fiduciary or trust relationship with his patient.¹⁹ This means the doctor has a duty to act with utmost good faith: he must never allow his professional duty to conflict with his

14. Everett v. Griffiths [1920] 3 K.B. 163 (C.A.); Matheson v. Smiley [1932] 2 D.L.R. 787 (Man. C.A.).

15. Edgar v. Lamont [1914] S.C. 277 (Ct. Sess.); but see infra at p. 29.

16. Hurley v. Eddingfield (1901) 59 N.E. 1058 (Ind. S.C.); Godfrey, Emergency Care: Physicians should be placed under an affirmative duty to render essential medical aid in emergency circumstances (1974) 7 U. Calif. Davis L. Rev. 246 at 249.

17. See infra at p. 33.

18. Bagot v. Stevens Scanlon & Co. [1966] 1 Q.B. 197 (Q.B.D.). See also Bache case referred to at [1973] L.S.U.C. Lec. 156.

19. Kenny v. Lockwood [1932] 1 D.L.R. 507 (Ont. C.A.); Halushka v. University of Sask. (1965) 53 D.L.R. (2d) 436 (Sask. C.A.); Smith v. Auckland Hospital Bd. [1965] N.Z.L.R. 191 (N.Z.C.A.); Hopper, The Medical Man's Fiduciary Duty (1973), 7 Law Teacher 73. The relationship has been compared to that of parent and child, man and wife, confessor and penitent or guardian and ward. Henderson v. Johnston [1956] O.R. 789.

personal interests;²⁰ he must not mislead his patient. This fiduciary duty is the foundation for the requirement that his patient's questions be honestly answered and that any consent obtained be an informed one.²¹ It is also the reason that fee-splitting is illegal.²²

In summary the relationship of a doctor and patient results in the creation of a duty owed by the doctor to the patient. The duty has both legal and equitable aspects. Historically it has been part of the law of common calling, implied contract and negligence. The doctor's duty in modern times is within the flexible framework of negligence and it is to use reasonable care, skill and judgment in the practice of his profession.

(b) Characteristics

The doctor-patient relationship begins when the doctor agrees to treat the patient who has expressly or impliedly requested his services. This is true whether or not the doctor is paid.²³ Ethical consideration aside, the doctor is not required to accept any

20. Ralston v. Tanner (1918) 43 O.L.R. 77; Wasmuth, Law for The Physician, Lea and Febiger, Philadelphia, 1966.

21. Kenny v. Lockwood supra n. 19; Reibl v. Hughes (1977) 16 O.R. (2d) 306; on appeal a new trial was ordered (1978) 6 C.C.L.T. 277 (Ont. C.A.); Dickens, Contractual Aspects of Human Medical Experimentation (1975), 25 U.T.L.J. 406 at 426.

22. Henderson v. Johnston supra n. 19.

23. Speller, Law of Doctor and Patient (1973); Haines, Courts and Doctors (1952) 30 Can. Bar Rev. 483 at 487.

patient.²⁴ He may even refuse a patient though no other doctor is available.²⁵

Once the relationship exists however, the doctor is obliged to attend the patient for as long as good medical practice requires. Factors relevant to determine what length of time this might be include the patient's condition, the nature of the illness, and the availability and quality of other medical care.²⁶

The patient may dismiss the doctor at any time²⁷ but the doctor must be very cautious should he decide to terminate the relationship. The doctor should give a patient reasonable notice that he plans to discontinue his services. The best way to do this is to write a letter to the patient explaining the situation and allowing time for the patient to obtain other medical assistance. If possible, the document should be given to the patient or sent by double registered mail.

When a patient in need of treatment has severed the relationship with the doctor or discharged himself from hospital, the doctor is in a strong position to prove he did not abandon the case if he has a state-

24. Nathan, supra n. 12.

25. See authorities listed supra n. 16.

26. Baltzan v. Fidelity Ins. Co. [1932] 3 W.W.R 140, affirmed without reasons [1933] 3 W.W.R 203 (Sask. C.A.); Stark v. College Phys. & Surg. of Sask. (1965) 52 W.W.R 157, affirmed without reasons (1966) 55 W.W.R. 121; Stetler and Moritz, Doctor and Patient and the Law 123, 4th ed., C.V. Mosby, St. Louis, 1962.

27. In an early case, Town v. Archer (1902) 4 O.L.R. 383 at 386 it was said that consulting another doctor without the knowledge of it by the first is tantamount to a dismissal of him. It is doubtful whether this applies today.

ment to this effect signed by the patient.²⁸ Whatever the action or reaction of the doctor to the termination of services, it must be reasonable in the circumstances, or he may be found liable for abandonment of the patient.²⁹

Whether an urban specialist with weekly office hours or a rural general practitioner who makes house calls, the doctor is free, within the doctor-patient relationship and with the patient's consent, to determine time, place and type of medical treatment.³⁰

The roles of the doctor and patient have received close scrutiny from the social scientists who believe that the type of relationship may have a profound effect on the practice of medicine.³¹ The traditional relationship is one in which the patient is passive and the doctor active, as in the emergency situation. Another common type of interaction is one in which the doctor, like the parent, gives guidance and direction and the patient, like the child, is expected to co-operate. It is assumed the both doctor and patient are actively working in the patient's best interests. For some patients with chronic diseases the relationship of mutual participation may be more suitable: the doctor is helping the patient to help himself. Critics

28. Speller, supra n. 23; for suggestions as to proper statements see Stetler and Moritz, supra n. 26.

29. Waltz and Inbau, Medical Jurisprudence 147, MacMillan Co., New York, 1971; See also Rosenthal, Physician's Abandonment of Patient (1975) 7 N. Carolina Cent. L. J. 149.

30. Louisell and Williams, Medical Malpractice, Matthew Bender, New York 1969; See also Waltz and Inbau, id. at 149.

31. Szasz and Hollender, The Physician-Patient Relationship in Gorovitz et al., Moral Problems in Medicine, Prentice Hall, Englewood Cliffs, N.J., 1976.

of the active-passive and guidance-co-operation relationships say the doctor is too much in control and the patient is vulnerable to exploitation. The doctor is told to stop playing the traditional "father image" role.³² A more reasonable approach would seem to be for the modern doctor to remain in control of diagnosis and treatment but where possible to assist the patient to be an informed, active participant.

In whatever role the doctor is seen, he gives and the patient expects to receive, certain reassurances. But the doctor is not an insurer of his patient's health. He does not normally warrant that his treatment will be beneficial nor does he guarantee a cure.³³ It may be otherwise if the doctor has entered into an express contract to produce a cure or certain results.³⁴ The distinction between a therapeutic assurance and a binding guarantee may not be clear to the ill or dissatisfied patient and could constitute a trap for the doctor.³⁵ The courts give some protection to the doctor by looking with suspicion on any claim that a doctor guaranteed a good result, unless he admits having done so, or a written agreement is produced to that effect.

Since 1968 and the enactment by the Canadian Parliament of the

32. Somers and Somers, Doctors, Patients and Health Insurance 476-82, Brookings Inst., Washington D.C., 1961; See also Kouri, The Patient's Duty to Co-operate (1972) 3 Rev. de D. Univ. Sherbrooke 44.

33. Johnston v. Wellesley Hospital (1970) 17 D.L.R. (3d) 139 (Ont.); Haines supra n. 23; Hughston v. Jost [1943] O.W.N. 3.

34. Allard v. Boykowich [1948] 1 W.W.R. 860 (Sask.).

35. Hawkins v. McGee (1929) 84 N.H. 114, 146 A. 641 (S.C.); Noel v. Proud (1961) 189 Kan. 6, 367 P. 2d 61 (S.C.); Giulment v. Campbell (1971) 188 N.W. 2d 601 (Mich. S.C.).

Medical Care Act³⁶ most doctors are paid on a fee-for-service basis by a provincial medicare plan. Canadians are covered by the plan for all medically required services provided by doctors.³⁷ In most provinces, more than ninety percent of the doctors have chosen to practice under the scheme.³⁸ Because the doctor's duty is founded on the doctor-patient relationship and not on contract the patient's status to sue is not affected where the services, though requested by the patient, are gratuitous or paid for by a third party.³⁹

There is some uncertainty about whether a doctor-patient relationship arises where the patient is being examined by a doctor at the request of a third party. This situation may arise when the patient requires a medical examination for employment, life insurance, or as a party to a law suit.⁴⁰ American authorities state there is no doctor-patient relationship in these circumstances.⁴¹ The English

36. R.S.C. 1970, c. M-8.

37. Andreopoulos, National Health Insurance 35, John Wiley & Sons, Toronto, 1975.

38. Id. at 55.

39. Thomson, Claims Arising Out of the Relationship Between Doctor and Patient [1963] L.S.U.C. Spec. Lec. 185 at 189. For a discussion of the situation where there is an express contract, see infra.

40. Causton v. Mann Egerton (Johnsons) [1974] 1 All E.R. 453 (C.A.).

41. Louisell and Williams, supra n. 29 at 191. But see [1975] Supplement 89 citing Beadling v. Sirotta (1964) 197 A. 2d 857 (N.J.S.C.) where the Appeal Court said at 860-861: "Whether or not a physician-patient relationship exists, within the full meaning of that term, we believe that a physician in the exercise of his profession examining a person at the request of an employer owes that person a duty of reasonably care.... (However) the scope of the duty owed is clearly not co-extensive with the duty owed to a private patient who seeks from the doctor a report as to the status of his health".

courts have faced the problem in a few unusual cases and after some division of opinion, have concluded that there is a duty owed by the doctor to a patient being examined and certified⁴² under mental treatment legislation. Thus, there was held to be a doctor-patient relationship although the patients whose mental health was in issue were not being examined at their own request. But these cases may be restricted by the facts.

Is there a doctor-patient relationship between the doctor named by an insurance company to do a medical examination and an applicant for insurance who submits to the examination? If there is, what is the scope of the duty owed by the doctor? Surely it would only be to use reasonable care in the conduct of the examination. Yet it might be broad enough to subject the doctor to liability if he fails to diagnose an obvious disease in the applicant. Unfortunately, there is no Canadian authority on this point.⁴³

The prudent doctor doing an examination at the request of a party other than the patient ought to make clear to the patient that many incidents of the doctor-patient relationship, such as confidentiality,

42. Nathan, *supra* n. 12; *Hall v. Semple* (1862) 3 F. & F. 337, 176 E.R. 151 (Nisi Prius); *Everett v. Griffiths* [1921] 1 A.C. 631 (H.L.); *Harnet v. Fisher* [1927] 1 K.B. 402; *De Freville v. Dill* (1927) 96 L.J.K.B. 1056. But see *Urquhart v. Grigor* (1864) 3 Macph. 283 (Ct. Sess.) and *Pimm v. Roper* (1862) 2 F. & F. 783, 175 E.R. 1283.

43. For a very recent Canadian decision, holding a doctor-patient relationship to exist, see *Leonard v. Knott* [1978] 5 W.W.R. 511 (B.C.S.C.). See *Wilcox v. Salt Lake City Corp.* (1971) 216 Utah 78, 484 P. 2d 1200 (S.C.). Waitresses sued city-employed doctors who had examined chest x-rays done pursuant to renewal of occupation permits. The doctors were negligent in their diagnosis but it was held that the waitresses had no action because there was no duty owed to them by the doctors.

are absent and encourage the patient to seek advice, care and treatment from his own doctor. A Canadian court faced with the issue of whether, in the circumstances, the relationship of doctor and patient existed would have to consider the knowledge the patient had of the situation and the roles of the doctor and the third party.

While both doctor and patient have a certain latitude within which to establish the terms of their relationship, this freedom is now circumscribed by ethical, legal and practical restrictions.

2. Communications Between Doctor and Patient

(a) Basis for Confidentiality

Communication between a doctor and patient is essential to the relationship. The doctor requires data from the patient in order to give proper advice and treatment and the patient has a responsibility to co-operate providing it.⁴⁴ The patient may assume his confidences will not be revealed to third parties without his permission.

The Oath of Hippocrates sets out the moral obligations of the doctor. It reads:

Whatsoever I see or hear in the course of my practice, or outside my practice in social intercourse, that ought never to be published abroad, I will not divulge, but consider such things to be holy secrets.

44. Kouri, The Patient's Duty to Co-operate supra n. 32.

The Canadian Medical Association, like most others in the world, embodies this principle in its Code of Ethics. Rule six states:

An ethical physician will keep in confidence information derived from his patient, or from a colleague, regarding a patient and divulge it only with the permission of the patient except where the law requires him to do so; [emphasis supplied].

The requirement of confidentiality arises from the doctor-patient relationship and is older than the common law. Thus, if there is no relationship, there is no obligation on the doctor to remain silent.⁴⁵ If, for example, a doctor riding as a passenger in a taxi cab observed the driver, not being a patient of his, to be ill and unfit to perform his duties, the doctor would be justified in reporting this to the proper authorities, and in some provinces would be protected by statute from liability for doing so.⁴⁶

The communications protected by the ethical duty not to disclose may be in any form, oral or written.⁴⁷ The type of information which is protected is broad and includes not only that concerning the patient and his illness but also knowledge about the patient's family.⁴⁸

45. In the U.S. the relationship of doctor-patient does not exist unless treatment is contemplated. Thus examinations done for eligibility for insurance or employment, are not within the relationship and the information obtained from the patient is not privileged. Stetler & Moritz, supra n 26 at 261.

46. For example, Motor Vehicle Administration Act, 1975 (Alta.), c. 68, s. 14(2). See also Canadian Medical Association, Guide for Physicians in Determining Fitness to Drive a Motor Vehicle 2 (1974).

47. Nokes, Professional Privilege (1950) 66 L.Q.R. 88 at 91.

48. Speller, supra n. 23 at 127.

Sometimes the doctor is required to divulge confidential information. These situations can be best discussed as inside or outside of a court of law.

(b) Disclosure inside a Court of Law

The search for truth, which is the goal of the judicial process, requires that all material facts be before the court. Occasionally courts are prepared to do without evidence that would be relevant and probative because its disclosure would harm a relationship important to society.⁴⁹ Evidence which is thus excluded is said to be "privileged".

Communications made within the doctor-patient relationship are not privileged. This means that if a doctor is asked a question and has the answer, though the question intrudes into the secrets told him by his patient, he must reply.

It is only the lawyer who can, within certain limitations, refuse to reveal confidences of his client. The justification for this unique treatment is that it is essential to the protection of basic human rights that an individual feel free to make a full disclosure to his legal advisor.⁵⁰

The rule that communications between doctor and patient are not privileged in the courtroom has remained unchanged since the celebrated

49. Sopinka and Lederman, The Law of Evidence in Civil Cases 156 (1974).

50. Id. at 158. See also Greenough v. Gaskell (1833) 1 My. & K. 98 at 103, 39 E.R. 618 at 620 (Ch.).

dictum of Lord Mansfield in the bigamy trial of the Duchess of Kingston in 1776.⁵¹ Mr. Hawkins, the surgeon who had attended the lady, was called as a witness, and asked whether he knew "from the parties of any marriage between them". He replied that he did not know "how far anything that has come before me in a confidential trust in my profession should be disclosed, consistent with my professional honour".⁵² Lord Mansfield thereupon stated the law as follows:⁵³

...a surgeon has no privilege where it is a material question, in a civil or criminal cause, to know whether the parties were married or whether a child was born, to say that his introduction to the parties was in the course of his profession, and in that way he came to the knowledge of it. I take it for granted that if Mr. Hawkins understands that, it is a satisfaction to him and a clear justification to all the world. If a surgeon was voluntarily to reveal these secrets, to be sure he would be guilty of a breach of honour, and of great indiscretion; but to give that information in a court of justice, which by the law of the land he is bound to do, will never be imputed to him as any indiscretion whatever. [emphasis supplied.]

Courts in Canada have followed this rule and require a doctor to give evidence.⁵⁴ Any doctor who refuses could be held in contempt of court and fined or even jailed.

In England there is some authority for the proposition that a judge has a discretion to refuse to require confidential information to be

51. Kingston's (Duchess) Case (1776) 20 State Tr. 619.

52. Id.

53. Id.; See also Wheeler v. LeMarchant (1881) 17 Ch. D. 675 (C.A.).

54. Halls v. Mitchell [1928] S.C.R. 125; R. v. Potvin (1971) 16 C.R.N.S. 233 (Que. C.A.); R. v. Burgess [1974] 4 W.W.R. 310 (B.C. Co. Ct.).

given in court. This dispensation by courtesy⁵⁵ was discussed in an obiter comment by Lord Denning in A.G. v. Mulholland:⁵⁶

The only profession that I know which is given a privilege from disclosing information to a court of law is the legal profession, and then it is not the privilege of the lawyer but of his client. Take the clergyman, the banker or the medical man. None of these is entitled to refuse to answer when directed to by a judge. Let me not be mistaken. The judge will respect the confidences which each member of these honourable professions receives in the course of it, and will not direct him to answer unless not only it is relevant but also it is a proper and, indeed, necessary question in the course of justice to be put and answered. A judge is the person entrusted, on behalf of the community, to weigh these conflicting interests - to weigh on the one hand the respect due to confidence in the profession and on the other hand the ultimate interest of the community in justice being done....

While it has been stated that Canadian courts do not have a general discretion to exclude evidence which is highly probative and relevant,⁵⁷ there is authority for the exercise of judicial discretion to protect the communications between patient and psychiatrist.⁵⁸

Privilege has been given by statute in Quebec where the Medical Act states: "No physician may be compelled to declare what has been

55. Freedman, Medical Privilege (1954) 32 Can. Bar Rev. 1 at 10.

56. [1963] 2 Q.B. 477 at 489, (C.A.).

57. R. v. Wray [1971] S.C.R. 272; Sopinka and Lederman, supra n. 49 at 205 and 217. But see R. v. St-Jean (1976) 34 C.R.N.S. 378 (Que. C.A.) and R. v. Hawke (1974) 3 O.R. (2d) 210 (H.C.).

58. See infra at p. 39.

revealed to him in his professional character".⁵⁹ The Charter of Human Rights and Freedoms⁶⁰ states that everyone has a right to non-disclosure of confidential information.⁶¹ These extensions of privilege might be limited by the legislative jurisdiction of the provinces.⁶²

More than two-thirds of the United States have statutes granting privilege to doctors, the first enacted in New York in 1828.⁶³ The result has been confusion and controversy about the doctor-patient relationship.⁶⁴ Critics of the granting of privilege note that it is more often used by plaintiffs to exclude evidence that would defeat or limit their claim for money and not to protect them from humiliation or embarrassment at all⁶⁵ and therefore truth which ought to be disclosed is suppressed.⁶⁶ Exceptions to the legislation have

59. R.S.Q. 1964, c. 249, s. 60(2) [re-en. 1973, c. 46, s. 40]; See also Carter v. Carter (1974) 53 D.L.R. (3d) 491 (Ont.) where a judge exercised discretion and did not require a doctor to give evidence about the respondent's venereal disease on the ground that it would be contrary to the public interest to make such information public knowledge.

60. Charter of Human Rights and Freedoms, 1975 (Que.), c. 6, s. 9.

61. Newfoundland also grants privilege to religious advisors: Newfoundland Evidence Act, R.S.N. 1970, c. 115, s. 6.

62. R. v. Potvin supra n. 54; but see R. v. Sauve [1965] Que. S.C. 129 where it was held that the civil law and not the common law applied with respect to privilege in criminal cases; comment at (1965) 15 Rev. du B. 562; See also R. v. Hawke supra n. 57.

63. Waltz & Inbau, supra n. 29 at 236.

64. Stetler & Moritz, supra n. 26 at 253.

65. DeWitt, Privileged Communications Between Physician and Patient 33, Chas. C. Thomas, Springfield, 1958.

66. 8 Wigmore on Evidence 838-32 (3d ed. 1961).

proliferated and recent draft law reform does not provide for privilege at all. One American authority says the death knell has sounded for doctor-patient privilege in his country.⁶⁷

In Europe, most countries provide for doctor-patient privilege. Indeed many Continental codes set out civil and even criminal remedies for the patient whose confidences have been revealed by a doctor.⁶⁸

Should the law in Canada be changed to give a doctor professional privilege? What criteria should be used in making the decision?

Wigmore,⁶⁹ an American authority on the law of evidence, has set out four requirements for the establishment of professional privilege. These have been approved as conditions precedent for the extension of privilege by the Supreme Court of Canada in Slavutych v. Baker:⁷⁰

- (1) The communications must originate in a confidence that they will not be disclosed;
- (2) This element of confidentiality must be essential to the full and satisfactory maintenance of the relationship between the parties;
- (3) The relationship must be one which in the opinion of the community ought to be sedulously fostered; and

67. Waltz & Inbau, supra n. 29 at 253.

68. Hammelmann, Professional Privilege: A Comparative Study (1950) 28 Can. Bar Rev. 750.

69. Wigmore, supra n. 66 at 531.

70. [1975] 4 W.W.R. 620 (S.C.C.); see also Strass v. Goldsak (1975) 58 D.L.R. (3d) 397 (Alta. C.A.). For a comment see McLauchlin, Confidential Communications and the Law of Privilege (1977) 2 U.B.C.L. Rev. 266.

- (4) The injury that would inure to the relation by the disclosure of a communication must be greater than the benefit thereby gained for the correct disposal of litigation.

Does the communication between doctor and patient meet the four tests?⁷¹

- (1) Do communications by patients originate in a confidence that they will not be disclosed? The fairest answer would seem to be, not always. It has been pointed out that many patients speak freely to friends, neighbours and relatives about their ailments.⁷²
- (2) Is confidentiality essential to the doctor-patient relationship? An obvious but rather weak answer is it cannot be because the medical profession has carried on without it for centuries. The McRuer Commission's findings⁷³ were that patient care had not been affected by the absence of privilege. There is some force in the argument that the traditional general practitioner-patient relationship was more dependent on confidentiality than the modern super-specialist-patient relationship. There is also the problem of which medical professionals would qualify. Privilege exists by

71. Freedman, supra n. 55 at 5.

72. See Law Reform Commission of Canada, Law of Evidence Project, Report, Professional Privileges Before the Courts 12 (1975) where it has also been suggested that Canadians are less reluctant to a limited public disclosure than Europeans!

73. Royal Commission into Civil Rights, 2 Report No. 1 822 (1968).

statute in Quebec⁷⁴ yet there is no evidence to show that the doctor-patient relationship is treated any differently there than in the common law provinces.

- (3) Should the relationship be fostered by the community? Yes. There is no disagreement on this point.
- (4) Would the injury to the relation from disclosure be greater than the social benefit? There would be no injury to many relationships. It might be otherwise if the subject matter is venereal disease or abortion, but to completely seal the lips of the doctor is to invite injustice.⁷⁵ The proper administration of justice is fettered where relevant probative evidence is kept from the court. For example, if there was privilege the patient could exclude all unfavourable medical evidence in a personal injury claim. Clearly, there are some situations where the social benefit is greater.

However, the relationship between psychiatrist and patient may often fulfill Wigmore's tests⁷⁶ Perhaps it is for this reason that some Canadian courts have refused to compel a psychiatrist to give

74. Medical Act, R.S.Q. 1964, c. 249, s. 60(2) [re-en. 1973, c. 46, s. 40].

75. R. v. Stewart, Alta., McDonald J., 1977 (unreported); Freedman, supra n. 55 at 6.

76. See Sharpe, Legislative Recognition of A Physician-Patient Privilege (1975) 23 Chitty's L.J. 64 at 66 wherein it is suggested psychiatrists may be "a special breed of physician who require the certainty of confidentiality even if their brethren can exist without it".

evidence. In Dembie v. Dembie⁷⁷ the wife's psychiatrist was called by the husband and asked to reveal information affecting the wife's right to alimony. The psychiatrist refused to answer saying the information was highly confidential and to reveal it would be a breach of professional secrecy and the Hippocratic Oath.

Stewart J., refusing to force the psychiatrist to testify said:

...I think it inimical to a fair trial to force a psychiatrist to disclose the things he has heard from a patient, and, in addition to that, I think it rather shocking that one profession should attempt to dictate the ethics of another, which the courts are doing when they see fit to state what a doctor will say and what he will not. They are forcing a breach of [the Hippocratic] oath, and the legal concept that the doctor is not breaching it, that he shall not disclose anything a patient shall tell him unless mete to do so, the idea that it is mete when he gets in the witness box is nonsense....

Landreville J. in G. v. G.,⁷⁸ a custody action in which a husband on examination for discovery refused to reveal communications made to a marriage counsellor, commented in dicta that full disclosure between psychiatrist and patient was "fundamental to the practice of psychiatry" and "can only be obtained if the patient knows that what he is to say and hear will be of strict confidential nature".⁷⁹

77. Ont., April 16, 1963 (unreported); referred to in (1964-65) 7 Cr. L.Q. 305 at 316.

78. [1964] 1 O.R. 361.

79. Id. at 365-6. In the U.S. similar arguments have been advanced on behalf of psychologists and social workers. In twenty of the United States privilege has been extended to clinical psychologists, Curran & Shapiro, Law, Medicine and Forensic Science 381, Little, Brown & Co., Boston, 1970. In Canada see Kirkpatrick, Privileged Communications in the Correctional Services (1964-65) 7 Cr. L.Q. 305.

Haines J. in R. v. Hawke⁸⁰ commented that not only might Wigmore's four tests be met in the appropriate case of psychiatric evidence but that there was an additional ground for protecting a witness from disclosure of his psychiatric history.⁸¹

What of the right of privacy of a witness, or the right to privilege from disclosure of communication in circumstances an ordinary citizen would consider confidential? Our federal Government may be said to have expressed a Government policy in the recent wiretap legislation. If private telephone conversations are to be protected from electronic eavesdropping, how much more important is it to protect the confidential communications between doctor and patient, whether that patient seeks assistance voluntarily or has the relationship thrust upon him by involuntary admission procedures when he is placed in hospital? The doctor to whom he speaks has taken an oath of secrecy based on concepts older than our common law. He is responsible in damages if he violates that relationship. Everyone recognizes that confidentiality is essential to diagnosis and therapy. Indeed, one may go further and say public health is involved if those requiring assistance refrain from seeking it for fear that it will be disclosed. No better illustration of the disaster that could befall a man is needed than the disclosure that a political candidate or an incumbent of office has received psychiatric treatment.

It has been suggested the communication of a patient to a psychiatrist may be protected from disclosure on other bases too.⁸² The psychiatrist might be acting in the capacity of conciliator where spouses are honestly attempting to reconcile their differences.⁸³ If the psychiatrist was appointed by the court he would be prohibited by

80. Supra n. 57. The Ontario Court of Appeal chose not to deal with the trial judge's comments on this point but to remark somewhat tersely that obiter comments on the rights of witnesses were inappropriate. See R. v. Hawke (1975) 29 C.R.N.S. 1 (Ont. C.A.).

81. Supra n. 57 at 226.

82. See R. v. Pettipiece [1972] 5 W.W.R. 129 (B.C.C.A.) and Perras v. R. [1973] 5 W.W.R. 275 (S.C.C.).

83. Sopinka and Lederman, supra n. 49 at 202 and 207.

the Divorce Act⁸⁴ from revealing conversations with the parties.

There are courts refusing to follow this trend. In R. v. Potvin⁸⁵ a criminal case to which the provincial legislation allowing privilege in civil cases was held inapplicable, the Quebec Court of Appeal allowed an appeal on the ground that the trial judge had erred in ruling a psychiatrist had professional privilege. Dembie v. Dembie⁸⁶ was distinguished in R. v. Burgess⁸⁷ and the statements made by an accused to a psychiatrist were held admissible. The court was sympathetic to the psychiatrist for the patient relationship being accorded special consideration but ruled that once the evidence was given by the psychiatrist, it could not be held inadmissible.

It appears that the law of evidence requires modification to allow privilege to cover some doctor-patient relationships. This could be brought about by Canadian judges following the example of their English brethren and assuming greater discretion to exclude evidence.⁸⁸

84. R.S.C. 1970, c. D-8, s. 21 states that:

(1) A person nominated by a court under this Act to endeavour to assist the parties to a marriage with a view to their possible reconciliation is not competent or compellable in any legal proceedings to disclose any admission or communication made to him in his capacity as the nominee of the court for that purpose.

(2) Evidence of anything said or of any admission or communication made in the course of an endeavour to assist the parties to a marriage with a view to their possible reconciliation is not admissible in any legal proceedings.

85. Supra n. 54.

86. Supra n. 77.

87. Supra n. 54.

88. See supra at p. 34.

Wigmore's four tests could be used as the criteria for determining whether a particular doctor-patient relationship merited privilege. Indeed this approach has recently received strong judicial approval.⁸⁹ The Law Reform Commission of Canada is studying the possibility of legislation.⁹⁰ Should such a statute recognize privilege and set out specific limitations to its application or should the courts be given a discretion to grant privilege in the appropriate cases?⁹¹

The Law Reform Commission of Canada in its Report on Evidence⁹² recommends that the courts be granted a discretionary power. Section 41 of the Evidence Code states:

41. A person who has consulted a person exercising a profession for the purpose of obtaining professional services, or who has been rendered such services by a professional person, has a privilege against disclosure of any confidential communication reasonably made in the course of the relationship, if, in the circumstances, the public interest in the privacy of the relationship outweighs the public interest in the administration of justice.

89. Slavutych v. Baker; Strass v. Goldsack; McLauchlin; all supra n. 70.

90. Law Reform Commission of Canada supra n. 72. For support for legislation as the answer see Haines J. in R. v. Hawke supra n. 57 at 227. See also Hammelmann, supra n. 68 at 758.

91. Ludwig, The Doctor's Dilemma (1975) 6 Man. L.J. 313 at 315.

92. Law Reform Commission of Canada Report on Evidence 80 (1977).

The English Law Reform Committee agrees that the trial judge should be given a discretion.⁹³

In summary, the doctor-patient relationship is not privileged in a court of law. Exceptions exist by statute in Quebec for a doctor in a non-criminal case and from time to time by judicial courtesy for communications between a psychiatrist and patient. There is a need to provide for privilege in some doctor-patient relationships. Reform could be brought about by judicial or legislative action.

(c) Disclosure outside a Court of Law

(i) Under statute

Just as the search for truth by the judicial system results in an intrusion into confidentiality between doctor and patient, so does the public interest in safety and health care. In all of the provinces of Canada there are statutes requiring the doctor to divulge information obtained from a patient.⁹⁴

93. Law Reform Committee 16th Report Privilege in Civil Proceedings, Cmnd. No. 3472 at 21-22 (1967); Meredith, supra n. 60 at 23 made the strong recommendation that the North Carolina statute providing for judicial discretion be enacted across Canada. In this he was following the 1937-38 report of the American Bar Association's Committee on the Improvement of the Law of Evidence. Representations made by the medical profession to this Committee indicated that doctors were satisfied with the exercise of judicial discretion.

94. In the U.S. a statutory requirement of disclosure has been compared to qualified privilege in defamation. See Smith v. Driscoll (1917) 94 Wash. 441, 162 P. 572 (Wash. S.C.).

The earliest provisions were found in acts dealing with communicable and venereal disease⁹⁵ and vital statistics⁹⁶ and involved reporting to public officials. The expansion of medical care and the need for its assessment as well as the proliferation of health and social services has greatly expanded the legislation and increased the bodies entitled to have access to the confidential data of patients.

Certain statutes provide for the transmission of confidential information for reasons that include the protection of public health, the assessment of standards of health care, the improvement of procedures, the fostering of research and teaching, the obtaining of vital data such as deaths and births, the protection of children and the compensation of workers.⁹⁷

There is an attempt in some of the legislation to protect the identify of the patient or to require the recipient of the information to keep it confidential.⁹⁸

95. E.g. (as amended): Public Health Act, R.S.A. 1970, c. 294; Venereal Diseases Prevention Act, R.S.A. 1970, c. 382.

96. E.g. (as amended) Vital Statistics Act, R.S.A. 1970, c. 384.

97. See for example, these Alberta statutes (as amended). Tuberculosis Act, R.S.A. 1970, c. 374; Naturopathy Act, R.S.A. 1970, c. 257; Venereal Diseases Prevention Act, R.S.A. 1970, c. 382; Alberta Hospitals Act, R.S.A. 1970, c. 174; Mental Health Act, 1972 (Alta.), c. 118; Cancer Treatment and Prevention Act, R.S.A. 1970, c. 38; Coroners Act, R.S.A. 1970, c. 69 [re-en. 1976, c. 66, "Fatality Injuries Act"]; Vital Statistics Act, R.S.A. 1970, c. 384; Child Welfare Act, R.S.A. 1970, c. 45; Workers' Compensation Act, 1973 (Alta.), c. 87.

98. For example, in regard to venereal disease, cancer treatment, mental health care, hospital patients and child battery. See also Carter v. Carter supra n. 59 where evidence from records of a health officer that a party to an action may have had venereal disease was held inadmissible on grounds that it was in the public interest to encourage persons to be treated in the knowledge that their affliction will be kept confidential.

The patient who is unfit to drive a motor vehicle is specifically dealt with by many provinces. For example, in Quebec,⁹⁹ British Columbia¹⁰⁰ and Ontario¹⁰¹ a doctor is required to report to a public official the name of a patient whom he considers unfit to drive.¹⁰² In Alberta a doctor is encouraged to report such a patient¹⁰³ and the statute purports to protect the doctor from liability for doing so.¹⁰⁴

If the public is to be protected and if medical science and care is to advance, access to information, albeit confidential, is essential. This need must, however, be balanced with protection of the confidentiality of the doctor-patient relationship.

(ii) By consent of the patient

A. Express

If the patient consents, the doctor is free to disclose confiden-

99. Transport Act, 1972 (Que.), c. 55, s. 86.

100. Motor Vehicle Act, R.S.B.C. 1960, c. 253, s. 208 [en. 1969 c. 20, s. 54].

101. Highway Traffic Act, R.S.O. 1970, c. 202, ss. 142-144 [s. 142(1) am. 1977, c. 54, s. 18]. See Gordon v. Wallace (1973) 2 O.R. (2d) 202 at 206.

102. In England, a doctor was convicted of failing to give the police information about one of his patients as required by the Road Traffic Act 1972: R. v. Hunter, The Times, 9 February 1974.

103. Motor Vehicle Administration Act, 1975 (Alta.), c. 68, s. 14(2), (3).

104. Id. See discussion, infra.

tial information to whomever the patient designates. However, for his own protection the doctor should get the consent in writing. An example would be a patient requesting that his doctor send a summary of his medical history to an employer, lawyer, insurer or another doctor.

The right of confidentiality is the patient's. Thus, if the patient requests that the doctor divulge information the doctor cannot refuse. In an English case¹⁰⁵ a doctor refused to respond to the request of his patient to provide a medical report which would have shown the patient had venereal disease. The doctor said he would only give his evidence in court, but the judge ruled that the doctor had to provide the information as requested by the patient.

The Quebec Medical Act¹⁰⁶ states "No physician may be compelled to declare what has been revealed by him in his professional character" and would seem to give the doctor the right to make the decision.¹⁰⁷ But Quebec courts have interpreted this provision as giving the patient the right to compel the doctor to give evidence about his medical care¹⁰⁸ although the doctor can decide what he should or should not say.¹⁰⁹

105. C. v. C. [1946] 1 All E.R. 562 (P.D.A).

106. Medical Act, R.S.Q. 1964, c. 249, s. 60(2) [re-en 1973, c. 46, s. 40].

107. Hebert v. La Cie d'Assurance Sur La Vie de la Sauvegarde (1927) 66 Que. S.C. 32 at 36.

108. Mutual Life Ins. Co. v. Jeannotte-Lamarche (1935) 59 Que. K.B. 510 at 529; Rheault v. Metro. Life Ins. Co. (1939) 45 R.L.N.S. 446 (Que. S.C.); Gagne v. Alliance Nationale (1946) 13 I.L.R. 13 (Que. S.C.).

109. Mutual Life Ins. Co. v. Jeannotte-Lamarche, *id.*

Those jurisdictions which have enacted statutes granting privilege¹¹⁰ have provided that the patient shall be the one who decides whether the privilege will be invoked or waived.

Compelling the doctor to speak puts him in a difficult position. He may be forced to give information which he believes harmful to the patient or to others. There may be judgments and conclusions he has not previously revealed to the patient¹¹¹ because he believes to do so would be deleterious. Some judges have taken the view that there is a public interest in safeguarding professional secrets.¹¹² This opinion is shared by authorities in France and other European countries where even the consent of the patient does not free a doctor from his duty of secrecy.¹¹³

Nevertheless the interest of the public or the medical profession in safeguarding medical information should not outweigh the interest of the patient in having access to his own medical information, for himself or for those to whom he wishes to make it available.¹¹⁴

110. Some U.S. states, the State of Victoria in Australia, and New Zealand.

111. Hammelmann, supra n. 68 at 756; Gordon v. Wallace (1973) 2 O.R. (2d) 202.

112. Hebert v. La Cie d'Assurance Sur La Vie de la Sauvegarde, supra n. 107.

113. Hammelmann, supra n. 68 at 757.

114. Rozovsky, Canadian Hospital Law 65 (1974).

B. Implied

There are situations where the patient's consent may be reasonably implied; for example, to allow the doctor to consult with colleagues, or arrange for nursing care or therapy. However, some discretion should be exercised in responding to questions about a patient if they be from a colleague.¹¹⁵

Is there implied consent to release information about the patient to a spouse or other members of the family? Canadian authorities 20 years ago answered yes to this question.¹¹⁶ Today the answer has to be qualified. On the one hand good medical public relations and common sense say there are family members who must be told for example, that a patient has had a miscarriage. On the other hand, the patient may not want anyone to know of this fact and she has the right to have the information kept confidential. Ideally, the patient should be asked to appoint a person to whom the doctor can speak freely. This has the added advantage of sparing the doctor numerous explanations. If this has not been done or is not possible, it is probably reasonable for the doctor to speak to a spouse or near relative such as a parent, brother or sister. It may be otherwise if he is aware of family strife. If a doctor took a very rigid approach and refused to speak to anyone about

115. The Medical Defence Union, Annual Report 1975 21 reports a case where a doctor responded to questions asked by another doctor about a patient on the belief that the patient would be attending at the latter doctor's hospital. In fact the inquiring doctor was a relative of the patient and on the other side of a family dispute.

116. Freedman, supra n. 55 at 19; Meredith, supra n. 60 at 24.

the patient his practice would likely suffer.¹¹⁷

Making information available to those beyond the family, such as to an employer, is fraught with risk.¹¹⁸ In any case, the doctor should avoid giving information over the telephone except to someone the patient has named and whose voice he recognizes. The parents or guardians of a minor child who is under their legal control probably have a right to information.

Whether consent to release information can be implied or not is a question of fact. Should a patient object to the release of information the doctor has the onus of providing that there was consent.

(iii) In the public interest

Concern for the protection of the public may cause the doctor as a responsible citizen to breach the duty of confidentiality to his patient. When does a doctor's duty to society so outweigh his duty to maintain secrecy that he is justified in revealing information about his patient of his own accord?

The authorities now agree that if a doctor learns that a serious crime such as murder, rape, robbery or kidnapping is about to be committed or has been committed he should contact the police.¹¹⁹ Some

117. A.B. v. C.D. (1904) 7 Fraser's S.C. 72 (Scot. S.C.); Furniss v. Fitchett [1958] N.Z.L.R. 396 (N.Z.S.C.).

118. Medical Defence Union, Law and the Doctor 52 (1975); Hopper, The Medical Man's Fiduciary Duty *supra* n. 19.

119. Speller, *supra* n. 23 at 132; Meredith, *supra* n. 60 at 26; Rozovsky, Canadian Hospital Law 76 (1974); Freedman, *supra* n. 55 at 14.

go so far as to question whether a doctor-patient relationships should even exist where the patient is such an extreme threat to society.¹²⁰ The attitude of the medical profession on this question has changed dramatically in the last thirty years, due in part, no doubt, to the grave threat posed to society by the increase in violent crime.¹²¹

But the doctor who decides to put society's interests first is doing so as a matter of conscience because there is no legal duty to assist the police. For while it is a criminal offence to obstruct the police in their investigations,¹²² it is not an offence to refuse to assist them.¹²³

The protection of children who have been mistreated by adults justifies a doctor breaching his duty of confidentiality.¹²⁴ Indeed in many jurisdictions there is legislation requiring the reporting of an abandoned, deserted or physically ill-treated child.¹²⁵

120. Speller, id.; Freedman, id. at 17.

121. See Chafee, Is Justice Serviced or Obstructed by Closing Doctor's Mouth on Witness Stand? (1942-43) 52 Yale L.J. 607, wherein it is reported that the American doctor who went to prison for two years rather than report to the police that he had treated the fugitive Dillinger for gunshot wounds was commended by Lancet, a well-known British Medical journal. Compare with Medical Defence Union, Annual Report 1968 20-21 where it is stated that in certain circumstances a doctor might be under a duty to report an unfit driver or give information to protect a battered child.

122. Criminal Code, R.S.C. 1970, c. C-34, s. 127(1) [re-en. 1972, c. 13, s. 8].

123. R. v. Semenik (1955) 111 C.C.C. 370 (Alta.).

124. Medical Defence Union, supra n. 118, n. 121.

125. E.g. Child Welfare Amendment Act, 1973 (Alta.), c. 15, s. 41. Note that Alberta provides for a penalty for the failure to do so.

A patient who is unfit to drive by reason of illness or alcohol or drug abuse is a great risk to society. While some provinces have enacted statutes requiring a doctor to report such a patient, others say the doctor may do so or are silent on the point.¹²⁶ None of the acts sets out a penalty for the failure to report. Thus, the doctor is thrown back to weighing the duty to society against the duty not to disclose information about a patient. Modern authorities would support the doctor who reports.¹²⁷ The victim of a patient-driver whom a doctor failed to report could sue the doctor, relying on the legislation as the source of the duty of care.¹²⁸ It is arguable that such accidents are those which the legislation is intended to prevent, and that such victims are those it is intended to protect, and therefore the criteria for reliance on a statutory duty of care would be satisfied. But such a claim might be rejected on the principle of remoteness as to both liability and damages.¹²⁹ There is no doubt that a doctor should warn a patient of the dangers of continuing to

126. Supra at p. 46.

127. Medical Defence Union, supra n. 118 at 52; Sharpe, Driving, Disease and the Physician's Responsibility (1975) 23 Chitty's L.J. 99. But see Meredith, supra n. 60 at 309. In a panel discussion of the Canadian Bar Association in 1953 opinions were expressed that a doctor would be unwise to tell the Department of Highways that a patient was an epileptic. See Problems in Litigation (1953), 31 Can. Bar Rev. 503 at 535.

128. Sharpe, id. at 102; New Horizons in Medical Ethics: Confidentiality [1973] 2 British Med. J. 700 at 701; Doctors, Drivers and Confidentiality [1974] 1 British Med. J. 399. See also Boomer v. Penn (1965) 52 D.L.R. (2d) 673 (Ont.).

129. Gootson v. R. [1947] 4 D.L.R. 568 at 579 aff'd [1948] 4 D.L.R. 33 (S.C.C.).

drive when disease or treatment affects his ability to do so.¹³⁰

A doctor is required, by statute, to report communicable and venereal disease to the proper authorities.¹³¹ It may be unwise for the doctor to do more.¹³² If he knows a third party is at risk, as the wife of a patient who has venereal disease, he should certainly bring this to the attention of the medical officer of health.¹³³ The information is thereby kept within the medical profession and, presumably, held confidential but the third party will be properly protected. In an American case, Simonsen v. Swenson¹³⁴ a doctor advised a hotel manager that a patient staying at the hotel had syphilis. The court found this to be a breach of confidence but held that there was an over-riding duty to society to prevent the spread of this disease. Likewise an English authority¹³⁵ has concluded that if disclosure was made by the doctor to the third party to protect her against the risk of infection to which a patient was exposing her, a court would be unlikely to award damages against the doctor. But a

130. Canadian Medical Association supra n. 46 at 2.

131. See R. v. Gordon (1923) 54 O.L.R. 355 where a doctor was prosecuted for failing to report a case of diphtheria. He was not convicted as it was found that he did not have the necessary mens rea, or mental intent required by law, to commit the offence.

132. Note that in Ontario a doctor can give information to the patient's family for the protection of health: Venereal Diseases Prevention Act, R.S.O. 1970, c. 479, s. 13(3).

133. Gray, Law and the Practice of Medicine 39, Ryerson Press, Toronto, 1947.

134. (1920) 104 Neb. 224, 177 N.W. 831 (Neb. S.C.).

135. Speller, supra n. 23 at 134.

recent Ontario case seems to require strict confidentiality when venereal disease is diagnosed. In Carter v. Carter¹³⁶ evidence that a party to the action may have had venereal disease was ruled inadmissible. The judge stated that since venereal disease statutes encourage persons to seek treatment on the basis that it will be held confidential, it is not in the public interest to reveal the information. The best advice for the Canadian doctor is to avoid divulging information about the patient's venereal disease to those who might be infected unless there is no other way to protect them.

Society must be protected against violent criminals, dangerous drivers, child batterers and persons with serious diseases. In such situations a doctor should act to protect the public even when so doing requires him to breach his duty of confidentiality to his patient.

(d) Actions for Breach of Confidence

Four situations in which a doctor may be justified in disclosing information about a patient have been discussed:

1. when giving testimony in a court of law;
2. when the patient has expressly or impliedly given his consent;
3. where there exists a statutory duty;
4. where it is demanded by the public interest.

136. Supra n. 59.

In situations other than these, a disclosure is wrongful, and certain legal consequences follow for the doctor.¹³⁷

A wrongful disclosure of information is a breach of a doctor's ethical duty,¹³⁸ for which he could be subjected to disciplinary proceedings by his profession¹³⁹ for conduct unbecoming a physician and be reprimanded, suspended or even struck off the register.¹⁴⁰

However, as punitive to the doctor as these administrative proceedings may be, they do not compensate the patient. For this, the patient must sue the doctor in a civil action.

Over two hundred years ago Lord Mansfield emphasized that a doctor who voluntarily revealed secrets would be "guilty of a breach of honour, and of great indiscretion",¹⁴¹ but there have been few occa-

137. For this discussion it is assumed that the disclosures are true, for if they are not the appropriate action might be defamation. For a discussion of defamation see infra.

138. See supra at p. 25. Note that in Furniss v. Fitchett supra n. 117 this ethical duty was said to be far broader than any common law duty. Note also that it is a breach of ethical duty to reveal information about a dead patient: Medical Defence Union, supra n. 118 at 52. Winston Churchill's physician was criticized for revelations he made concerning his famous patient. See (1965) 2 Lancet 785-6. See also Robitscher, Doctors' Privileged Communications, Public Life, and History's Rights (1968) 17 Clev.-Marsh. L. Rev. 199.

139. In Alberta, Medical Profession Act, 1975 (Alta.), c. 26, ss. 34, 56. In Ontario, Health Disciplines Act, 1974 (Ont.), c. 47 s. 60(3), (5).

140. In 1969 in England, a doctor who discussed a patient with a third party was held to have committed "infamous conduct in a professional respect" and was erased from the register: Medical Defence union, supra n. 118 at 51.

141. Supra n. 51 at 573.

sions where this statement of a legal duty has been tested in the courts.¹⁴² One of these rare cases was A.B. v. C.D.¹⁴³ where a doctor who had examined the wife of an elder of the Presbyterian Church, revealed in a report put before the Kirk Session that "the pregnancy had commenced before marriage". The doctor, who was sued for a breach of professional confidence argued that secrecy was not part of the contract¹⁴⁴ between the patient and doctor but merely an "honourable understanding",¹⁴⁵ the breach of which could not be the basis for a law suit. The Scottish court was unanimous in finding otherwise and for the patient's husband who had sued. Lord Fullerton said:¹⁴⁶

The question here is...whether the relation between such an adviser and the person who consults him, is or is not one which may imply an obligation to secrecy, forming a proper ground of action if it be violated. It appears to me that it is...that a medical man, consulted in a matter of delicacy, of which the disclosure may be most injuries to the feelings, and possibly, the pecuniary interests of the party consulting, can gratuitously and unnecessarily make it the subject of public communication, without incurring any imputation beyond what is called a breach of honour, and without the liability to a claim of redress in a court of law, is a proposition to which, when thus broadly laid down, I think the Court will hardly give their countenance.

142. Note that most of the Continental codes create a strict duty of professional secrecy a breach of which makes the doctor liable for damages; Hammelmann, supra n. 68.

143. (1851) 14 Dunlop's S.C. 177 (Scot. C.S.).

144. See infra at pp. 22.

145. Supra n. 143 at 179.

146. Supra n. 143 at 180. This reasoning was accepted in a later Scottish case, but with the caution that "it must depend on circumstances whether any disclosure made to others is a wrong, for which compensation may be sought by an action of damages in a court of law." A.B. v. C.D. supra n. 117 at 81.

A paucity of judicial authority notwithstanding, the New Zealand Supreme Court made a cautious extension of the law in the 1958 case of Furniss v. Fitchett.¹⁴⁷ Reviewing our modern concept of the duty of care as expressed in the famous case of McAlister (or Donoghue) v. Stevenson,¹⁴⁸ the learned Chief Justice found to be included in the doctor's duty of care to his patient the obligation of confidentiality. However, he restricted the case to those situations in which the doctor can reasonably foresee the information coming into the patient's knowledge and causing physical harm, and where the public interest does not require disclosure.

The case has been soundly criticized¹⁴⁹ but remains important because it found a duty, albeit narrow, against wrongful disclosure upon which the award of damages was based.

In spite of a dearth of strong authority a well known English text states that in the proper case the Courts would find there was a legal duty not to disclose anything about a patient and grant the remedy of damages or an injunction to a patient who has suffered loss or damage to his reputation or perhaps only embarrassment as a result of the doctor's breach of his duty of confidentiality.¹⁵⁰

American authorities hold that a doctor is liable to his patient for damages arising out of a truthful but wrongful disclosure of

147. Supra n. 117.

148. [1932] A.C. 562 (H.L.).

149. Fleming, English Law of Medical Liability (1959) 12 Vanderbilt L. Rev. 633 at 643.

150. Speller, supra n. 23 at 128.

medical confidences.¹⁵¹

A patient has a natural right to control the promulgation of information about himself. It is now clear that a patient will be compensated where his doctor, whose duty it is to respect that right, wrongfully discloses information.

On what basis should such actions be brought: contract, tort or fiduciary relationship?¹⁵² This is a practical question to be determined in the future.¹⁵³ Each cause of action has its advantages and limitations, but the negligence action appears to be the most flexible framework within which to resolve these claims.

151. Stetler and Moritz, supra n. 26 at 271-2; see for example, Simonsen v. Swenson supra n. 134. The Americans too have had a few of these kind of cases; see Hanning and Brady, Extrajudicial Truthful Disclosure of Medical Confidences: A Physicians Civil Liability (1967) 44 Denver L.J. 463, wherein it is stated that from the Simonsen case to 1967 there were only 7 cases in the entire U.S.

152. Salmond on Torts 10 (16th ed. Heuston 1973); Gorback v. Ting [1974] 5 W.W.R. 606 at 607 (Man.); for an excellent discussion of these see Boyle, Medical Confidence - Civil Liability for Breach (1973) 24 North. Ireland L.Q. 19 and Hopper, supra n. 19.

153. It is unclear whether a cause of action under any of these heads would survive the death of the patient. See supra n. 138.

CHAPTER III

CIVIL ACTIONS

This chapter outlines the nature of the various civil actions which might be brought by a patient against a doctor. The actions which are most commonly used will be discussed in depth in later chapters.

It is important to note at the outset that a plaintiff may have more than one cause of action available out of one set of facts. For example, a patient who suffers burns as a result of treatment for acne might bring actions against his dermatologist based on negligence, battery or even breach of contract.

1. Assault and Battery¹

A patient who has been touched without his consent has suffered a trespass to his person and can sue for the torts of assault and battery. An important feature of these torts is that the patient need not have suffered any damage to bring the action.²

Battery is committed by intentionally bringing about harmful or offensive contact with another. The essence of the action is the

1. For a general discussion, see Fleming, The Law of Torts.23-6 (5th ed. 1977).

2. McNamara v. Smith [1934] 2 D.L.R. 417 (Ont. C.A.).

touching of another without his consent, so the individual is protected not only against bodily harm but also against any interference with his person which is offensive to honour and dignity. Accordingly a person may be battered although he is asleep or unconscious at the time of the touching.

An assault is the apprehension of a battery.³ Normally, a person is apprehensive if unauthorized physical contact is imminent, and so it has been said that assault and battery go together like ham and eggs.⁴ But the actions can occur separately: when one is unconscious or otherwise unaware of an impending battery, or when one is threatened but no actual contact takes place. The term "assault" is often used today to cover assault and battery together or even battery itself.⁵ "Surgical assault" is sometimes used to refer to a battery which has been committed by a doctor on a patient. Assault and battery involving force are crimes as well as torts and are dealt with by the Criminal Code.⁶

The validity of both of these actions depends on the absence of the victim's consent, which is a complete defence to the assault and battery action. So, while the treatment and care of patients necessitates touching, many potential assault and battery actions against doctors

3. Supra n. 1 at 26.

4. Prosser, Law of Torts 41 (4th ed. 1971).

5. See Gambrielle v. Caparelli (1974) 7 O.R. (2d) 205 where it has been suggested that the nomenclature be changed to reflect modern usage.

6. R.S.C. 1970, c. C-34, ss. 244-46 [ss. 244-45 re-en. 1974-75-76, c. 93, ss. 21-22; s. 246 am. 1972, c. 13, s. 22].

are precluded on this basis.

The consent may be implied from the patient's conduct. For example, when he presents himself and complains of certain symptoms he is impliedly consenting to such examination as is reasonable for diagnosis and treatment.⁷ Written consent is not a requirement in most jurisdictions⁸ but should be obtained if possible when surgery or dangerous tests are involved, as it protects the doctor by providing him with some proof that consent has been given.

In an emergency, the doctor needs no consent from the patient; he can touch the patient as necessary to treat him and no liability will follow for assault and battery.⁹ However, the importance of obtaining consent in a non-emergency situation cannot be overstressed.¹⁰ A patient who has not consented will have a good cause of action whether or not he has suffered harm and even if he has benefitted from the authorized treatment.¹¹

7. O'Brien v. Cunard S.S. Co. (1891) 154 Mass. 272, 28 N.E. 266 (S.C.).

8. But see, for example, R. Regs. M. 1970 P130-R1, s. 6; N.B. Reg. 66/47 (1966) as amended, s. 40; Ont. Reg. 100/74 (1974), ss. 49, 49a; 7 Quebec Statutory Regulations 183 as amended, s. 3.2.1.11; Sask. Reg. 285/74 (1974) as amended, s. 50.

9. Marshall v. Curry [1933] 3 D.L.R. 260 (N.S.S.C.). For an unusual case see Leigh v. Gladstone (1909) 26 T.L.R. 139 (K.B.), a case which involved doctors' force feeding women prisoners.

10. For a full discussion of cases see infra Chapter 4.

11. Mulloy v. Hop Sang [1935] 1 W.W.R. 714 (Alta. C.A.).

2. False Imprisonment

Of the same family as trespass to the person, false imprisonment protects the liberty of the individual as well as his reputation and dignity.¹² While no damage need be proven the plaintiff must show he was restrained that that no reasonable avenue of escape was available. He need not be conscious of his confinement.¹³

The tort is committed by failing to release a person so entitled or by confining an individual against his will without lawful authority. Therefore, since a patient is free to refuse medical treatment, confining him or forcing treatment upon him without statutory¹⁴ authority could render the doctor liable for false imprisonment. However, not many such actions are brought against doctors.

One example of this situation is the case of Coulombe v. Watier,¹⁵ in which the patient sued the psychiatrist who had arranged for his admission to a mental institution. The certificate leading to

12. See Fleming, supra n. 1 at 26.

13. Linden, Canadian Tort Law 45 (1977).

14. See, for example, the following statutory provisions authorizing medical care or examinations without consent in certain circumstances: Child Welfare Act, R.S.A. 1970, c. 45, s. 17; Corrections Act, 1976 (Alta.), c. 62, s. 30(11); Mental Health Act, 1972 (Alta.), c. 118, s. 26 [re-en. 1973, c. 76, s. 4]; Occupational Health and Safety Act, 1976 (Alta.), c. 40, s. 15; Tuberculosis Act, R.S.A. 1970, c. 374, s. 7; Venereal Diseases Prevention Act, R.S.A. 1970, c. 382, ss. 3 and 9. See also Draper, Due Process and Confinement for Mental Disorders (1976), 14 Alta. L.R. 266.

15. [1973] S.C.R. 673. See also McIntosh v. Homewood Sanitarium [1940] O.W.N. 118 (H.C.); Swadron, The Legal Aspects of Compulsory Confinement of the Mentally Disordered (1962), 5 Cr. L.Q. 175.

the patient's confinement was not signed by the defendant but by another doctor who was not sued. The patient was released the day after his admission to the hospital. The Supreme Court of Canada held that the doctor sued was not liable for false imprisonment but the doctor who had signed the certificate might have been, had he been sued.¹⁶

There are patients who because of their very poor mental or physical condition may require some restraint. For example, the epileptic with a propensity to wander or leap from windows may require close supervision;¹⁷ the elderly patient who tends to fall out of bed may need securing; the patient with an infectious disease may call for isolation. Although none of these measures would generally lead to liability for false imprisonment, it ought to be remembered that in general, a patient must be allowed to leave a hospital if he demands to do so and he must not be given medication to make this impossible for him nor deprive him of the means of leaving by such tactics as refusing to return his clothes, money or personal effects. However, should a patient choose to reject the advice of his doctor and leave a hospital he ought to be required to sign a document setting out the facts and containing a statement that he is leaving against medical advice.

16. Although in the U.S., the certifying doctor is not usually held liable, for various policy reasons. See Sauer, Psychiatric Malpractice: A Survey (1971-72) 11 Washburn L.J. 461 at 464.

17. University Hospital Bd. v. Lepine; Monckton v. Lepine [1966] S.C.R. 561.

3. Negligence

(a) General

Negligence is the most common basis for a lawsuit against a doctor or hospital. Malpractice¹⁸ is a term that is often applied, sometimes even in statutes,¹⁹ to negligent practice but the scope of its meaning is not clear.²⁰ Until the term is adequately defined by the legislature or the courts its use is best avoided. The classical definition of "negligence" is:²¹

...the omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do.

Liability for negligence will not be found unless the following factors are present:

- (a) the defendant must owe a duty to the plaintiff to exercise

18. Meredith, Malpractice Liability of Doctors and Hospitals at xii (1956); McQuay v. Eastwood (1886) 12 O.R. 402 (C.A.).

19. See, for example, Dental Association Act, R.S.A. 1970, c. 90, s. 32; Dental Auxiliaries Act, R.S.A. 1970, c. 91, s. 8; Limitation of Actions Act, R.S.A. 1970, c. 209, s. 55 [am. 1973, c. 13, s. 7; 1975, c. 26, s. 82].

20. For example, it has some times included assault and battery. See Davy v. Morrison [1931] 4 D.L.R. 619 at 623 (Ont. C.A.); Boase v. Paul [1931] 4 D.L.R. 435 at 438 (Ont. C.A.); Schweizer v. Central Hospital (1974) 6 O.R. (2d) 606 at 607 (H.C.).

21. Blyth v. Birmingham Waterworks Co. (1856) 11 Exch. 781, 156 E.R. 1047.

care;

- (b) the defendant must breach the standard of care established by law for his conduct;
- (c) the plaintiff must suffer loss or injury as a result of this breach;
- (d) the conduct of the defendant must be the "proximate cause" of the plaintiff's loss or injury.

It is clear that a doctor has a duty to his patient to exercise reasonable care toward him and not to expose him to unreasonable risk of harm.

A person holding himself out as having a special knowledge or skill will have his conduct judged by the standard of the reasonable member of his profession, and so a doctor must meet the standard of the average reasonable doctor. This "standard of care" as it is called will be discussed in more detail later on.²²

The doctor will only be held liable for negligence if it results in loss or injury to the plaintiff; liability may still be escaped if the damage suffered is held to be too "remote" from the negligent act; that is, although the negligence may be the "factual" cause of the plaintiff's injury, it may not be the legal or "proximate" cause.²³

22. See infra Chapter 5.

23. See infra Chapter 5.

(b) Negligence and Other Actions

Of the many differences between negligence and the other actions such as assault and battery and false imprisonment, the most important is that negligence is not an "intentional" tort. A doctor will be held liable for battery only if he intended to touch the patient, but he may be held liable for negligence in the absence of any intention to perform in a negligent or substandard way.

Another difference between the two types of action is that in the negligence action, as noted above, damage must be proven, whereas in assault and battery such proof is not necessary to establish liability.²⁴

The patient's case is complete once he proves the doctor intentionally interfered with his person. The onus of establishing the defence of the patient's sufficient and effective consent is on the doctor.²⁵

A unique quality of the negligence suit is that it is possible in some cases to find some negligent conduct on the part of both parties. For example, a court might hold that the doctor was negligent by prescribing a certain drug but that the patient was also negligent by not reporting suspicious side effects. In such cases, the patient's conduct is referred to as contributory negligence and his recovery is reduced by the degree, expressed in terms of a percentage, to which he has been found negligent. Therefore, if it were found that 30% of the

24. Failure to prove damage will result however in the plaintiff's receiving only nominal damages. See supra Chapter 1.

25. Schweizer v. Central Hospital supra n. 20.

negligence which caused the patient's injuries was his own, and his damages were assessed at \$15,000.00, he would be entitled to recover from the doctor only the remaining 70% or \$10,500.00.

There has been confusion in Canadian jurisprudence as to whether battery or negligence is the proper action to bring in cases where consent to medical treatment is in issue. A survey of the cases indicates both have some use.²⁶ Many practical consequences ensue from the choice.²⁷ For example, because in negligence it must be proven that the doctor's substandard conduct caused the patient's injury, expert evidence is required to establish the proper standard of care and the extent of the plaintiff's injuries. However, in the battery action it need only be shown that the doctor intentionally touched the patient, and so expert evidence, if required at all, is only relevant to the question of whether there has been a valid consent by the patient.

The very basic theoretical differences between the actions noted above have been raised and discussed in two recent cases, Kelly v. Hazlett²⁸ and Reibl v. Hughes.²⁹ The course the law will take awaits further judicial determination.³⁰

26. For an analysis of the cases and further comment see Picard, The Tempest of Informed Consent in Canadian Studies in Tort Law (2nd ed. Klar 1977).

27. Id. See also Lischnikowsky v. Graham (1977) 5 A.R. 5 (S.C.), where an application to amend a statement of claim in negligence to include assault and battery was allowed.

28. (1976) 1 C.C.L.T. 1 at 24 (Ont. H.C.).

29. (1977) 78 D.L.R. (3d) 35; on appeal a new trial was ordered (1978) 6 C.C.L.T. 227 (Ont. C.A.).

30. Lepp v. Hopp (1977) 2 C.C.L.T. 183; reversed (1979) 8 C.C.L.T. 260 (Alta. C.A.), now on appeal to S.C.C.

4. Contract

It was recognized over three hundred years ago that a contract existed between a doctor and his patient, the breach of which afforded the patient a cause of action.³¹ But the tort of negligence better covered most situations where a patient was given substandard medical care and very few suits were brought for breach of contract alone.³²

A most common yet confusing approach of some courts was to discuss both the contract action and the tort action and their attributes without making clear which was the more appropriate.³³ One explanation for these failures to distinguish the actions is that the standard of care and skill required in a contract action is the same as that required in the tort action.³⁴ An example of the uncertainty of the bar and bench over the two actions is the Saskatchewan case, Allard v. Boykowich³⁵ where counsel for the plaintiff, who sued the defendant dentist in tort, amended to contract, assuring the court that it was not a tort action,³⁶ and yet at the close of the trial applied

31. Everard v. Hopkin (1615) 2 Bulst. 332, 80 E.R. 1164; Slater v. Baker (1767) 2 Wils. 359, 95 E.R. 860. See also supra Chapter 2.

32. See supra Chapter 2.

33. See, for example, Hughston v. Jost [1943] O.W.N. 3; G. v. C. [1960] Que. Q.B. 161.

34. Louisell and Williams, Medical Malpractice 197, Matthew Bender, New York, 1969.

35. [1948] 1 W.W.R. 860 (Sask. K.B.).

36. Id. at 866.

for leave to set up the claim in tort.³⁷ The patient claimed that extractions and dentures had not corrected her speech defect as promised by the dentist. She lost on the contractual ground, and the late application to amend being disallowed, the issue of negligence was never decided.³⁸

A contract is a legally enforceable agreement between two or more persons.³⁹ The basic requirements for the existence of a contract are that:

- (1) there be an intention to create legal relations;
- (2) the parties be known and competent;
- (3) the terms be certain or ascertainable;
- (4) there be consideration.

Are these requirements present in the doctor-patient relationship? There is no doubt that the relationship itself involves the intention to create legal relations.⁴⁰

It involves the purchase of professional services where the parties, patient and doctor, are known. The parties must be competent to contract and under no undue influence. However, the doctor in providing required professional services would be delivering necessities

37. Id. at 868.

38. Even if the amendment had been allowed the defendant might have pleaded res judicata (that the matter had been adjudicated upon). This possibility has been raised in U.S. courts. See Miller, The Contractual Liability of Physicians and Surgeons [1953] Wash. L.Q. 413 at 431.

39. Fridman, Law of Contract 3 (1976).

40. See supra Chapter 2.

of life for which even a minor, or in the case of an insane person, his estate, would be liable to pay.⁴¹

The terms of the contract for professional services will rarely be written or expressly discussed by the doctor and patient. Most often they are ascertainable by looking at the terms in the usual doctor-patient relationship.⁴² and the term usually implied by law to such contracts, for example the obligation of the doctor to exercise due care and skill⁴³ and to keep confidential the information he obtains.⁴⁴

To be enforceable a contract must be supported by consideration; that is there must be a balance of benefits and detriments on both sides.⁴⁵ In the contract between doctor and patient the doctor renders professional service and receives payment; the patient renders payment and receives services.⁴⁶ Thus, there is a balance of benefit and detriment on both sides as well as between the parties. Today doctors are paid through universal medical schemes for which the head

41. Supra n. 39 at 136-7 and 152.

42. Wasmuth, Law for the Physician 19, Lea and Febiger, Philadelphia, 1966.

43. Davy v. Morrison [1932] O.R. 1 at 6 (C.A.). This term implied in the contract is identical to the standard of care expected of the doctor by law, in a negligence action.

44. Furniss v. Fitchett [1958] N.Z.L.R. 396 at 397 (S.C.); see also supra Chapter 2.

45. Fridman, supra n. 39.

46. See Matheson v. Smiley [1932] 2 D.L.R. 787 (Man. C.A.) which held this to be true even where it is not the patient who engages the doctor. But see Allen v. Froh [1932] 1 W.W.R. 593 (Sask. C.A.).

of the household or another individual pay a premium. Indeed premiums may be waived in the case of the elderly or those on social assistance. The consideration must come from the person who receives the benefit and therefore it is arguable that since the patient himself may not be paying there is no consideration supporting the contract. However, the law requires only that a person receiving a benefit be required to do something in exchange for the benefit. The fact that what he is required to do may in fact be beneficial is irrelevant; the legal detriment lies in the requirement that it be done. Therefore, there is some support for the proposition that the patient, by submitting to treatment, is suffering an adequate detriment which could serve as consideration.⁴⁷

In conclusion, it would appear that the necessary contractual relationships can be found in most doctor-patient relationships.

The law suit based on an allegation of breach of contract presents advantages and disadvantages to both doctor and patient in terms of limitation periods, the expense of bringing the action, the damages recoverable and the acceptability of such an action by Canadian lawyers and judges.

The limitation period, or time period within which a person must sue, differs for tort and contract actions.⁴⁸ As a general rule, the patient must sue in tort within one year from the termination of professional services, whereas he has six years from the date of breach to

47. Supra Chapter 2.

48. See infra Chapter 6.

sue in contract.⁴⁹ So the patient who may have discovered his damage at too late a date to commence a negligence action may still be in time to sue in contract. However, the precise working of the relevant limitation statute must be examined closely because all actions against doctors may be covered by a broad definition or interpretation of the words which appear in many statutes: "... negligence or malpractice by reason of professional services requested or rendered ...".⁵⁰ This would mean that in any case where the defendant is a doctor, even a contract case, the shorter limitation time applicable to doctors would apply. But barring such an interpretation of the statute, a contract action gives the patient a longer time within which to begin an action and exposes the doctor to the risk of being found liable for a greater period.

The second factor relevant to the patient contemplating a contract action is that it will usually be less expensive to prove a case in contract than in tort against a doctor, for to succeed in a contract action the patient would have to prove only that a contract existed and that it had been breached. Put another way, all the patient has to do

49. Dickens, Contractual Aspects of Human Experimentation (1975) 25 U. T. L.J. 406 at 434; see also McLaren, Of Doctors, Hospitals and Limitations: "The Patient's Dilemma" (1973), 11 O.H.L.J. 85; Boase v. Paul, *supra* n. 20. Note that some U.S. jurisdictions have legislation making the time the same for both contract and tort actions against doctors. See Miller, The Contractual Liability of Physicians and Surgeons [1953] Wash. Univ. L.Q. 413 at 429.

50. Limitation of Actions Act, R.S.A. 1970, c. 209, s. 55 [am. 1973, c. 13, s. 7; 1975, c. 26, s. 82]. See Johnson v. Vancouver Gen. Hospital [1974] 1 W.W.R. 239 at 244 (B.C.C.A.); Phillippon v. Legate [1970] 1 O.R. 392 (C.A.).

is prove that the doctor made a promise and failed to perform it.⁵¹

By contrast, in a negligence action the patient must, by calling doctors who qualify as experts, prove the standard at which the doctor ought to have performed and perhaps call additional experts to prove the doctor did not do so. The patient must also prove injury or damage and the causal connection linking it to the doctor's treatment.

Assuming that the doctors who qualify as experts are prepared to testify against a colleague, it can, for various reasons, be difficult and expensive for the patient to arrange their appearance in court.

While the contract action may be open longer and be less expensive to the patient, it also has some disadvantages for him.

The purpose of damages in a contract case is to place the plaintiff in the position in which he would have been had the contract been performed; in a tort case, to restore the plaintiff to the condition in which he would have been had the tort not been committed.⁵² A number of consequences flow from this distinction.

For a breach of contract the doctor would be liable to pay only for the loss that reasonable persons in the positions of the doctor and patient at the time of the making of the contract would have considered likely to occur in the event of a breach by the doctor, whereas in tort the scope of liability is much broader: the doctor would be liable for all damage foreseeable to a reasonable person. This is a more flexible

51. Fridman, supra n. 39 at 547.

52. Id. at 559.

test and can include losses unlikely to occur;⁵³ for example, injuries of greater extent than would be expected, due to the patient's having, unknown to anyone, an abnormal weakness.⁵⁴ It could also include sums for such items as pain and suffering and mental anguish.⁵⁵

Although the extent of damages the doctor would have to pay could be less in a contract action, he may risk having to pay them from his own pocket if he has standard insurance coverage, which is usually for tort claims only.⁵⁶ To date the Canadian Medical Protective Association has not denied the request of a member to be assisted simply because he has been sued in contract. This may change if the number of contract actions increases sharply.

The contract action would seem to be more advantageous to patients than the tort action in the short run, but some authors believe it would have an extremely detriminal effect on the practice of medicine as doctors would have to be extremely cautious about what they said to

53. Linden, Canadian Negligence Law 253-277 (1972).

54. This is sometimes called the "thin skull" situation. See Linden, id. at 277-87.

55. Miller, supra n. 38 at 424; Bonebrake, Contractual Liability in Medical Malpractice - Sullivan v. O'Connor (1974) 24 De Paul L.R. 212 at 221. Note that in the U.S. damages normally awarded only in tort cases have been granted in contract cases; see Miller, supra n. 38 at 425.

56. See Dickens, supra n. 49 at 437. See also Birnbaum, Express Contracts to Care: The Nature of Contractual Malpractice (1974-75) 50 Indiana L.J. 361.

patients.⁵⁷ There is a thin line between a statement of mere opinion or a therapeutic reassurance which would not be a term of a contract and a representation of fact which might be.

In an early American case a doctor said to a badly burned patient, "I will guarantee to make the hand a hundred percent perfect hand". He was held to have made an express promise in spite of the fact that he was unskilled at skin grafting and argued that he had expressed an opinion which no reasonable person could interpret as a guarantee.⁵⁸

There is very little Canadian law or comment on the contract action and the doctor. One of the few discussions can be found in Hughston v. Jost⁵⁹ where Hope J. while finding against a doctor for negligence, indicated that an express contract is possible between a doctor and patient within which the doctor might agree to special terms or even to warrant or insure a certain result. The great potential for the action is shown by the large number of cases in the United States⁶⁰ and the growing comment on them.⁶¹

57. Miller, supra n. 38 at 419; Maynard, Establishing the Contractual Liability of Physicians (1974) 7 U. Calif. Davis L. Rev. 84 at 91-2; Bonebrake, supra n.55 at 226.

58. Hawkins v. McGee (1929) 84 N.H. 114, 146 A. 641 (S.C.); also Noel v. Proud (1961) 189 Kan. 6, 367 P. 2d. 61 (S.C.); Guilment v. Campbell (1971) 385 Mich. 57, 188 N.W. 2d 601 (S.C.).

59. Supra n. 33 at 4. See also Bernadot, De l'obligation de soigner dans le contract médical (1977) 37 Rev. de Bar 204.

60. See, for example, Sullivan v. O'Connor (1973) 296 N.E. 2d 183 (Mass. S.C.). See also authorities listed supra n. 58.

61. See, for example, Epstein, Medical Malpractice: The Case for Contract (1976) 35 Am. Bar Research J. 87; Maynard, supra n. 57; Bonebrake, supra n. 55; Birnbaum, supra n. 56. In general see Louisell and Williams, supra n. 34.

Lord Nathan⁶² recognized the contract action as a companion to the tort action. He saw in it a potential for liability which had not yet been realized: a doctor could be absolutely liable if the substances or materials he uses in his care or treatment cause damage or injury to the patient. This would be founded on the principle that there is implied in a contract to do work and supply materials an absolute warranty that the materials are reasonably fit for the purpose for which they are supplied.⁶³ This principle was applied in a case where veterinary surgeons inoculated the plaintiff's cattle with a defective toxoid.⁶⁴ The trial judge found there was an implied term in the contract between the owner and the veterinarian that the substances used for the inoculations would be reasonably fit for the purpose for which it was requested and that the term had been breached. The owners were awarded damages for loss of the cattle. It was not necessary for the owners to prove that the veterinarians were negligent in failing to discover the defect in the substance. In commenting on this case Lord Nathan says:⁶⁵

It is not easy to see why the same principle should not be applied, for example, to the case of a patient who employs his doctor to give him a course of injections against colds or an anaesthetist who is employed for the purposes of an operation. It would seem unreasonable if a less stringent contractual obligation were to be

62. Nathan, Medical Negligence 16 (1957).

63. Myers v. Brent Cross Service Co. [1934] 1 K.B. 46.

64. Dodd v. Wilson [1946] 2 All E.R. 691 (K.B.D.).

65. Nathan, supra n. 62 at 17. Note that in an English case, Samuels v. Davis [1943] 1 K.B. 526 (C.A.) it was suggested that a doctor could be liable for supplying defective equipment.

implied in the case of a contract to give an injection to a human being than in a contract for the inoculation of a cow.

A Canadian authority in the field of products liability⁶⁶ believes there may be policy considerations to justify exempting doctors from such strict liability,⁶⁷ but because no case has yet come before a Canadian court the question whether the contract between a doctor and patient contains an implied undertaking that all products supplied will be fit for the purposes intended is a matter of conjecture.

Thus, the contract action remains the silent, but perhaps potentially stronger companion of the negligence action; whether it would be acceptable in Canadian courts remains to be seen.

5. Defamation⁶⁸

Although there have been very few cases of defamation⁶⁹ brought

66. Waddams, Products Liability 92-3 (1974).

67. U.S. Courts have dealt with this by holding that there can be no strict liability unless there is a sale of the product rather than a service or supply of it. So the supply of tainted blood by hospitals has been held to be a service not a sale, resulting in no liability. See Waddams, id. at 40.

68. For a complete discussion of this area of tort law see Williams, The Law of Defamation in Canada (1976). See also Grange, The Silent Doctor v. The Duty to Speak (1973) 11 Osgoode Hall L.J. 81.

69. This is true even in the U.S. See Waltz and Inbau, Medical Jurisprudence 263, MacMillan Co., New York, 1971 for the report of a very early Canadian case where one doctor was held liable for defaming another by calling him a "butcher". See also Riddell, A Medical Slander Case in Upper Canada 85 Years Ago (1912-13), 46 Lancet 330.

against doctors, the action seems to be of concern to many and is a potential basis of liability.

A defamatory statement is any communication, oral or written, which would cause a person to be "shunned, avoided or discredited."⁷⁰

In the words of Salmond:⁷¹

The typical form of defamation is an attack upon the moral character of the plaintiff, attributing to him any form of disgraceful conduct, such a crime, dishonesty, untruthfulness, ingratitude or cruelty. But a statement may be defamatory if it tends to bring the plaintiff into ridicule or contempt even though there is no suggestion of any form of misconduct.

The statement must be "published",⁷² or communicated, to a third party and must refer to the person defamed.⁷³ The person to whom publication is made must understand what is said but whether he believes it or not is irrelevant.⁷⁴

In some jurisdictions in Canada, special legislation with respect to defamation has been enacted, and such statutes provide that the plaintiff need not prove his damage in such actions.⁷⁵

70. Williams, supra n. 68 at 6. Note that a College of Physicians and Surgeons has been held to be entitled to sue for defamation: College of Physicians and Surgeons of Sask. v. Co-Op Commonwealth Federation Publishing Etc. Co. (1965) 52 W.W.R. 65 at 77 (Sask. Q.B.).

71. Salmond on Torts 143 (16th ed. Heuston 1973).

72. See Williams, supra n. 68 at 58-68.

73. Id. at 11-13.

74. Fleming, supra n. 1 at 538.

75. Williams, supra n. 68 at 50.

However, in other jurisdictions the plaintiff must prove his damage unless the defamatory material constitutes libel, that is, it takes a permanent written form,⁷⁶ or unless the case involves an imputation:⁷⁷

- (1) which adversely reflects upon the plaintiff's business, trade, profession or calling;⁷⁸
- (2) that the plaintiff committed a serious crime;⁷⁹
- (3) that the plaintiff, if a woman, is unchaste;⁸⁰
- (4) that the plaintiff has or had a contagious or infectious disease.⁸¹

Of the defences to the action available we will discuss only the two most likely to avail a doctor: justification and privilege.

76. The historical importance of liable and slander and the modern differences are discussed by Williams, supra n. 68 at 53-55.
77. Williams, supra n. 68 at 50-53. See also Warren v. Green (1958) 25 W.W.R. 563 (Alta. S.C.).
78. See, for example, Warren v. Green id. where the defendant, at a meeting of the hospital district ratepayers, referred to the plaintiff doctor as a "quack". The court found the doctor to have been defamed and held that he did not have to prove his damages.
79. Willows v. Williams (1950) 2 W.W.R. 657 (Alta. S.C..) where it was held that a nurse was defamed by the Chairman of a hospital board who alleged that she trafficked in narcotics.
80. See C v. D. (1924) 56 O.L.R. 209 (H.C.) where the defendant doctor told the plaintiff patient, her father, and her employer that she had a venereal disease. However, qualified privilege was accepted as a defence.
81. See R. v. Z. [1947] Que. K.B. 457 (C.A.) where the plaintiff succeeded in a defamation action against the government because the manner in which its doctor employee arranged to examine him led to rumours that he had a venereal disease, which he did not.

It is important to remember that a defamatory statement is by definition false. Therefore the most obvious defence is to prove that the statement is true. This, the defence of justification, does however constitute the most dangerous defence to adopt, for two reasons. First, in order to prove that what he said was true, in both substance and fact,⁸² the defendant must prove some elements of defamation which will work to his disadvantage if he is unable ultimately to prove truth.⁸³ Second, should the truth defence fail, the damages awarded to the plaintiff may be increased, as the defendant's insistence on the truth of what he said will have tended to exacerbate the situation.

The defence of privilege⁸⁴ is of two kinds, absolute and qualified. A statement which is absolutely privilege can not be used by anyone as the basis for a defamation action. Such statements are, among others, those made in preparation for and during the course of a judicial proceeding such as a hearing or a trial.

Of greater interest to the doctor is the defence of qualified privilege. A statement made or written on certain occasions is not actionable provided it is made without malice, that is, spite or ill-

82. See, for example, Sabapathi v. Huntley [1938] 1 W.W.R. 817 at 827 (P.C.).

83. Williams, supra n. 68 at 117.

84. The meaning of "privilege" as it is used here ought to be distinguished from that which it carried in Chapter II. In that context, "privileged" describes a relationship such that at least one of the parties to it will not be required by a court to divulge communications made within it. In this context, "privileged" describes circumstances in which a person uttering defamatory words will not be held liable in defamation for the utterance.

will.⁸⁵ Such statements include those made:

- (1) in performing a duty;
- (2) in protecting an interest (such a property or reputation);
- (3) in a fair and accurate report of proceedings in a court or other tribunal (for example, a General Medical Council);
- (4) in a confidential communication arising out of a professional relationship.

Many doctor-patient communications fall into the first and last categories. To be covered by the first, the speaker or writer must have a legal, moral or social duty to make the comment and the recipient must have a corresponding interest in receiving it. Some examples exist in the few Canadian cases. In Arnott v. College of Physicians and Surgeons of Saskatchewan⁸⁶ a statement in a provincial medical journal that certain treatment was quackery was held to be privileged because the defendant College had a duty to make it and the doctors had a corresponding interest in receiving it. In C. v. D.⁸⁷ the defendant was the family doctor to the plaintiff, her father and her employer. A man the doctor was treating for a venereal disease named the plaintiff as the source of his infection whereupon the doctor told the employer that the plaintiff had an "infectious disease" and

85. See Sabapathi v. Huntley, *supra* n. 82 where malice was found when a defendant sent a letter to his business association condemning his medical treatment by the plaintiff doctor. Note also, it is the nature of the occasion, rather than the statement, which is privileged: Williams, *supra* n. 68 at 71.

86. [1954] S.C.R. 538.

87. Supra n. 80.

told her father that she had venereal disease. She did not, and sued. The doctor raised the defence of qualified privilege, and the court held that the doctor had a moral duty to warn those parties that he did of this dangerous disease and that they had a corresponding interest in receiving the information. It was further held that failure to examine the patient before making the statements did not show malice. Thus, the doctor was not liable for defamation because the statements were made in a privileged situation.

An important Canadian case, Halls v Mitchell⁸⁸ besides discussing the reciprocal duty and interest which was the basis for the decision in C. v. D. went on to deal with the effect of the confidential communication made in the course of a professional relationship.⁸⁹ At the time the issue of defamation arose the defendant doctor was the medical officer for the plaintiff's employer, but at an earlier time he had been the plaintiff's personal physician. While investigating the plaintiff's claim for workers compensation, the doctor communicated to others that the plaintiff had stated to him during this earlier time that he had suffered from a venereal disease. In fact none of this was true. The court warned that secrets acquired from a patient should not be divulged.⁹⁰ These statements of the Supreme Court of Canada are sufficiently broad that one author has concluded that a qualified privilege extends to confidential communications made in the course

88. [1928] S.C.R. 125.

89. Supra Chapter 2.

90. See supra Chapter 2.

of a doctor-patient relationship.⁹¹

From a doctor's perspective, it should be borne in mind that defamatory communications about a patient to a colleague, to a public health agency, to a member of the patient's family, or even to a member of the public will likely be covered by qualified privilege, in the absence of malice, so long as there is a duty to reveal and a reciprocal interest in obtaining the information. Similarly, criticism of colleagues will be privileged in these circumstances.

However, from a patient's point of view, it is wiser to express dissatisfaction with professional services to the College of Physicians and Surgeons since the law is extremely protective of the reputation of professionals.⁹²

91. Williams, supra n. 68 at 94.

92. Note that the British Medical Defence Union has advised against doctors' rushing into defamation actions. See Medical Defence Union, Law and the Doctor 41 (1975).

CHAPTER IV

CONSENT

1. Introduction

For centuries the law has protected the right to be free from offensive bodily contact,¹ but since touching is a necessary and often enjoyable incident of living in society it is also recognized that an individual may waive his strict right to bodily security. So a person who consents to being kissed in a movie, body-checked in a sporting event, or jostled in a crowded bus cannot collect damages for the torts of assault and battery.²

Physical contact with the patient is essential in virtually all medical treatment³ The doctor may need to palpate the abdomen, use a tongue depressor, or attach the electrodes of an electrocardiograph. In these examples the patient may have exceeded mere consent and

1. Salmond on Torts 122 (16th ed. Heuston 1973).

2. Supra Chapter 3.

3. For a discussion of the situation where there is no touching, as where the medical treatment involves the patient's taking drugs, see Gilborn, Legal Problems Involved in the Prescription of Contraceptives to Unmarried Minors in Alberta (1974) 12 Alta. L. Rev. 359 at 370 where the author concludes that it is not settled "[w]hether or not the giving of a pill could amount to such an 'application of force' as to constitute the tort of battery...." See also Rozovsky, Informed Consent and Investigational Drugs (1977) 1 Leg. Med. Q. 162 at 163.

actually have requested the examination or procedure. "Every human being of adult years and sound mind has a right to determine what shall be done with his own body...",⁴ so it might seem that bodily contact in medical situations differs little from that in social or sports situations. But there is an important difference in that the parties are not in an equal position because the doctor is far more knowledgeable about the condition of the body involved than the patient himself.⁵ In the past, when the doctor occupied a paternal role, there were fewer problems with consent because most patients expected and accepted his direction. While some modern patients continue to accept this traditional model of the doctor-patient relationship, many do not and want to know more about the medical treatment or procedure involved. Unfortunately, a few take this position only after an unpleasant experience.

On one side is the patient who has the right to examination, diagnosis, advice and consultation⁶ and, specifically, the right to a reasonably clear explanation of any treatment or procedure.⁷ He is presently being told that he is a consumer of medical services and that human rights are not being respected by health care professionals.⁸

4. Schloendorff v. New York Hospital (1914) 211 N.Y. 125 at 129, 105 N.E. 92 at 93 (N.Y.C.A.).

5. Kenny v. Lockwood [1932] 1 D.L.R. 507 at 520 (Ont. C.A.).

6. Parmley v. Parmley [1945] 4 D.L.R. 81 (S.C.C.).

7. Kenny v. Lockwood *supra* n. 5.

8. See Medical Malpractice (1977) 43 Consumer Reports 544, 598 and 674. See also Linden, Canadian Tort Law 58 (1977); Annas, Patients' Rights (1976) Harvard L.S. Bull. 31.

On the other side is the doctor who is highly trained to carry out complicated treatment with sophisticated tools. The nature of the explanation given to a patient about to undergo a dangerous or complicated procedure may be part of the treatment or therapy because his response to it might affect the results.⁹ There are those who believe the doctor is in the best position "to balance the patient's interest in his own body with the responsibility for the exercise of judgment by the doctor,"¹⁰ and that the patient is not assisted, but rather the doctor is "cribbed and confined"¹¹ by "participatory democracy and egalitarianism" which is the basis for requiring a full, informed consent by a patient.

This variance between the expectations and attitudes of doctors and patients with respect to consent to medical care is emphasized by a number of recent cases which will be discussed.

2. Forms of Consent

(a) Express Consent

Consent may be express in an oral or written form, but to say it is express does not say it is explicit. This is especially true of oral

9. McLean v. Weir (1977) 3 C.C.L.T. 87 (B.C.S.C.).

10. Scott, Report of General Counsel for the Year 1976 in Canadian Medical Protective Association, Annual Report 25 at 26 (1977).

11. Id. at 35.

consent. Rarely would a patient say, "I consent to a subclavian angiogram being carried out on my person by Dr. A at the B. Hospital on C date." His reply is likely to be a word or phrase indicating agreement or acquiescence.

Consent need not be written but this form may be more precise and provides excellent evidence that the patient's permission has been obtained. It is the practice of most hospitals to obtain consent in writing, especially for major treatment such as surgery¹² and in some jurisdictions it is a requirement.¹³ Many prototypes are available¹⁴ but even the most carefully worded, thorough form is worthless if the patient's consent lacks one of the pre-requisites for validity.¹⁵ Many forms presently in use are "blanket consents" authorizing unspecified additional or alternative procedures. Such a broadly worded consent might be so indefinite that a court would give it little weight.¹⁶ However, in practice, consent is more often implied than express.

12. Rozovsky, Canadian Hospital Law 42 (1974).

13. See, for example, R. Regs. Man. 1970, Reg. P130-R1, s. 6; N.B. Reg. 47/66 as amended, s. 40; Ont. Reg. 100/74, ss. 49, 49a; 7 Quebec Statutory Regulations 183 as amended, s. 3.2.1.11; Sask. Reg. 285/74 as amended, s. 50. See also, Schweizer v. Central Hospital (1974) 6. O.R. (2d) 606 (H.C.).

14. Supra n. 12 at 44. See also, Medical Defence Union, Consent to Treatment 13-23 (1974) for a complete set of forms.

15. Discussed infra.

16. Linden, supra n. 8; Rogers v. Lumberman's Mutual (1960) 119 So. 2d 649 (La. C.A.); Valdez v. Percy (1939) 35 Cal. App. 2d 485, 96 P. 2d 142 (Cal. D.C.A.).

(b) Implied Consent

Most consent to medical treatment is implied from the words or conduct of the patient.¹⁷

It is not hard to imply consent in the case of the patient who presents his arm for an injection,¹⁸ or opens his mouth for an examination.¹⁹ But it is sometimes difficult, especially in retrospect, for the doctor and patient to agree on the extent of the implied consent.

For example, in Reynen v. Antonenko²⁰ the plaintiff was taken to hospital by police to submit to a rectal search for drugs. At the hospital he removed his clothes and assumed the requested position. The defendant doctor performed the examination both by finger and sigmoidoscope and found drugs. The plaintiff sued the doctor for battery but the trial judge found that there had been an implied consent on the basis of the plaintiff's conduct and his words, "Let's go to the hospital." uttered when he was given the choice by the police either to remove the drugs himself or be taken to hospital. There was also testimony by the doctor that such an examination would have been impossible without the patient's cooperation.

17. Marshall v. Curry [1933] 3 D.L.R. 260 at 274 (N.S.S.C.).

18. O'Brien v. Cunard S.S. Co. (1891) 154 Mass. 272, 28 N.E. 266 (Mass. S.C.).

19. See Medical Defence Union, Law and the Dental Practitioner 7 (1974).

20. (1975) 30 C.R.N.S. 135 (Alta. S.C.).

There is no legal or medical test to determine how much can be implied from what a patient says or does.²¹ It is not quite clear whether a subjective or objective²² standard is to be applied to the patient.

A subjective test would require that all the characteristics of the particular patient be considered. This requires a doctor to know his patient fairly well but is consistent with the test used to determine the amount of information that a doctor need give a patient. However, an objective test would only consider what a "reasonable man" would be consenting to through words or conduct and would be more consistent with the test used in tort law generally.²³

On an analysis of the cases it appears that the subjective test is favoured in Canadian courts at this time,²⁴ but the final choice and clear enunciation of the test awaits judicial determination.

Because most conflicts over implied consent are reduced to contests over who had the best evidence it is a wise physician who gets consent in writing from the patient, or notes the words or actions from which he implied consent. The presence of a reliable witness can also be valuable.²⁵

21. See Rozovsky, supra n. 12 at 29. He suggests an objective test as a "useful guide".

22. See Nathan, Medical Negligence 160 (1957).

23. See Rozovsky, supra n. 12 at 29.

24. Picard, The Tempest of Informed Consent, in Studies in Canadian Tort Law 129 at 142 (2d ed. Klar 1977).

25. See Medical Defence Union, supra n. 19 at 7.

3. Special Situations

(a) Emergencies

A person may be unable to give consent due to unconsciousness or extreme illness. In such circumstances a doctor is justified in proceeding without the patient's consent, subject to a number of restrictions.

While the legal basis for substituting the doctor's decision for that of the patient has been debated by academics,²⁶ Canadian judges have taken a realistic approach. Refusing to strain the law to find consent, the courts recognize that sometimes a doctor may proceed without consent.²⁷

A few important Canadian cases illustrate the limits of this emergency doctrine.

In Marshall v. Curry²⁸ the doctor discovered a grossly diseased testicle in the course of a hernia repair operation. He removed the testicle firstly because it was necessary for the hernia repair and secondly because he judged it potentially gangrenous and therefore a menace to the patient's life and health. Because the patient was under general anaesthetic he proceeded without consent, and later the patient

26. For an excellent discussion, see Skegg, A Justification for Medical Procedures Performed Without Consent [1974] 90 L.Q. Rev. 512.

27. Marshall v. Curry *supra* n. 17.

28. Id.

sued for battery.²⁹ Prior to this case it had been held that in emergencies the doctor became the patient's representative to give his consent, but here the court refused to employ this reasoning and instead justified a doctor's action in emergency circumstances on "the higher ground of duty".³⁰ The Chief Justice of Nova Scotia said: "where a great emergency which could not be anticipated arises" a doctor can act without consent "in order to save the life or preserve the health of the patient".³¹ The action against the doctor was dismissed.

However in Murray v. McMurchy,³² a doctor who tied a patient's fallopian tubes because he had discovered fibroid tumours in the uterine wall while doing a Caesarian section, and was concerned about the hazards of a second pregnancy, was held liable. The trial judge found that while it was convenient to carry out the procedure at that time, there was no evidence that the tumours were an immediate danger to the patient's life or health.

Similarly, in Parmley v. Parmley³³ in which a patient requested the removal of two teeth and the defendant dentist extracted all of her upper teeth because he found advanced tooth decay and pyorrhea in the

29. Note that negligence was alleged in the pleadings but not proceeded with at trial. Id. at 263.

30. Id. at 275.

31. Id. at 275. But see Boase v. Paul [1931] 1 D.L.R. 562; affirmed [1931] 4 D.L.R. 435 (Ont. C.A.).

32. [1949] 2 D.L.R. 442 (B.C.S.C.).

33. [1945] 4 D.L.R. 81 (S.C.C.).

gums, the court held the dentist liable. Again there was no evidence of emergency and thus no basis for proceeding without consent; however an important obiter comment was made in the case:³⁴

There are times under circumstances of emergency when both doctors and dentists must exercise their professional skill and ability without the consent which is required in the ordinary case. Upon such occasions great latitude may be given to the doctor or dentist. [emphasis supplied]

A reconciliation of these cases leads to the principle that consent is unnecessary only where the procedure or treatment is required in order to save life or preserve health. Consent is required on all other occasions and it is no answer for the doctor to say that it was more convenient to perform the unauthorized procedure at that time or that he believed it was then that the patient would have wanted it done.³⁵

In short, our Canadian courts differentiate between a procedure that is "necessary" and one that is "convenient".

(b) Refusal to Consent

A patient has the right to refuse medical treatment,³⁶ and when

34. Id. at 89. See also Skegg, supra n. 26.

35. In Murray v. McMurchy supra n. 32, a witness testified that 97% of patients would be annoyed if the additional procedure of removing the tumours had not been taken.

36. Marshall v. Curry supra n.17 at 274; Rozovsky, supra n. 12 at 37; Skegg, supra n. 26 at 525.

this right is exercised, the doctor is put into a position where his ethical and legal duties conflict; whereas his professional commitment is to preserve life and health, he has no legal status to require a patient to preserve his own life or health.³⁷ The point is illustrated by an Alberta case, Mulloy v. Hop Sang,³⁸ where a surgeon found an amputation to be necessary and performed it in spite of the patient's twice stating that the doctor was not to amputate. The court agreed that the operation was necessary and was satisfactorily performed but held the doctor liable for performing an unauthorized operation. The fifty dollar damage award was said to be substantial by the 1935 court.

So proceeding with treatment that is forbidden by the patient may satisfy the doctor's ethics but leave him open to liability for battery.

If the patient involved is a minor, legislation in most provinces provides that the child can be made a ward of the government so that consent can be given for necessary medical treatment.³⁹ It is unlikely that a court in Canada would interfere with the decision of a competent adult by compelling medical treatment unless it is for the

37. Suicide is no longer a crime (see 1972 (Can.), c. 13, s. 16) but it is still an offence to counsel, aid or abet a person to commit suicide (Criminal Code, R.S.C. 1970, c. C-34, s. 224).

38. [1935] 1 W.W.R. 714 (Alta. C.A.).

39. See Child Welfare Act, R.S.A 1970, c. 45; Child Welfare Act, R.S.O. 1970, c. 64. Note that dependent adults are covered in Alberta by the Dependent Adults Act, 1976 (Alta.), c. 63, s. 9(1)(h). See Shapiro, Legal Aspects of Unauthorized But Necessary Medical Treatment [1963] L.S.U.C. Spec. Lec. 225 at 267. For the U.S. position see Raleigh Fitkin - Paul Morgan Memorial Hospital v. Anderson (1964) 201 A. 2d 537 (N.J.S.C.).

treatment of a communicable or venereal disease.⁴⁰ Most provinces have statutes providing for compulsory treatment in these special circumstances.⁴¹

A most difficult decision is faced by the doctor who is aware that an adult patient has prior to an emergency refused certain medical treatment, for example, the adult Jehovah's Witness carrying a card indicating that he refuses blood transfusions under all conditions but is incapable at the time of withholding consent. Two Canadian authorities have said that under such conditions treatment can be given without consent, because at the time of refusal, i.e., when the card was signed, the patient was not informed of the risks he now faces.⁴² However since a blood transfusion is generally indicated only when life is in serious danger, it is probably more logical to say that although the patient was not "informed" of the risk at the time he withheld his consent, he did contemplate that risk - death - and there-

40. See Sharpe, Consent to Medical Treatment (1974) 22 Chitty's L.J. 319 at 320. There is American case law to the same effect. See Erickson v. Dilgard (1962) 252 N.Y.S. 2d 705 (N.Y.S.C.); Re Brook's Estate (1965) 205 N.E. 2d 435 (Ill. S.C.). But there are many American cases contra. See Frenkel, Consent of Incompetents (Minors and the Mentally Ill) to Medical Treatment (1977) 3 Leg. Med. Q. 187 at 188.

41. See, for example, the following statutory provisions authorizing medical care or examinations without consent in certain circumstances: Child Welfare Act, R.S.A. 1970, c. 45, s. 17; Corrections Act, 1976 (Alta.), c. 62, s. 30(11); Mental Health Act 1972 (Alta.), c. 118, s. 26 [re-en. 1973, c. 76, s. 4]; Occupational Health and Safety Act, 1976 (Alta.), c. 40, s. 15; Tuberculosis Act, R.S.A. 1970, c. 374, s. 7; Venereal Diseases Prevention Act, R.S.A. 1970, c. 382, ss. 3 and 9.

42. Rozovsky, supra n. 12 at 39-40; Meredith, Malpractice Liability of Doctors and Hospitals 155-156 (1956).

fore to perform the procedure constitutes a battery. While it is possible that a court may follow this reasoning and hold the doctor liable, the damages for "wrongfully saving life" would of course be nominal.⁴³

The legal protection given to the patient's freedom of choice is cold comfort to a doctor struggling to make a decision which is in the patient's best interests.

4. Requirements

In a suit against a doctor in battery the patient must prove that he was touched and ought to testify that he did not consent. The doctor then has the onus of proving that the patient did consent.⁴⁴ The consent must meet certain requirements before it is acceptable as a defence.

These requirements are that it must be:

- (1) given voluntarily
- (2) given by a patient who has capacity
- (3) given by a patient who is informed
- (4) referable both to the treatment and the person who is to administer that treatment.

43. See Lepp v. Hopp (1977) 2 C.C.L.T. 183 at 195 (Alta. S.C.).

44. Schweizer v. Central Hospital supra n. 13; Kelly v. Hazlett (1976) 1 C.C.L.T. 1 (Ont. H.C.); Picard, supra n. 24. For a contrary opinion see Hertz, Volenti Non Fit Injuria: A Guide in Studies in Canadian Tort Law 101 (2d ed. Klar 1977).

A consent which is deficient with respect to any one of these requirements will be null; therefore each will now be examined in detail.

(a) Consent Must be Given Voluntarily

While it is true to state that the consent given must be the result of freedom of choice, an anxious, ill person, often with concerned family hovering and advising, will be unable to make a decision without some degree of fear, constraint or duress. However, it is usually easy to identify the extreme cases.⁴⁵ A consent is invalid if there was coercion or deceit involved, or a fraudulent misrepresentation of what was involved in the treatment to be undergone.⁴⁶ Should a doctor have reason to believe that the consent was given because the patient felt fear or compulsion from others, then he has a duty to discuss the matter with the patient alone.

A more difficult situation arises in cases where consent is obtained after the patient has received a pre-operative sedative. Two Canadian cases have dealt with this issue.

45. See Latter v. Braddell (1881) 50 L.J.Q.B. 448 (C.A.), where it was held that a housemaid who submitted most reluctantly to a physical examination ordered by her employer had consented to it. This case would be decided differently today.

46. See Re D and Council of College of Physicians and Surgeons of B.C. (1970) 11 D.L.R. (3d) 570 (B.C.S.C.). See also the American case of Hobbs v. Kizer (1916) 236 F. 681 (U.S.C.A. 8th Cct.). The doctor told the patient he operated for an abscess when, in fact, he performed an abortion. The patient's consent was not valid because of the fraud.

In the first case, Beausoleil v. Sisters of Charity,⁴⁷ a patient requiring a disc operation advised the anaesthetist that she wanted a general anaesthetic, not a spinal. This doctor called in the chief anaesthetist who had never examined the patient, but thirty minutes before the operation convinced her over her objections to submit to a spinal. When the patient later sued the chief anaesthetist for paralysis suffered as a result of the spinal, it was held that the consent was not voluntarily given because the patient was sedated and it was clear from her language that the spinal was the doctor's wish, not hers.

In Kelly v. Hazlett.⁴⁸ the patient was the aggressor. She had received pre-operative sedation in preparation for surgery involving an ulnar nerve transplant and a cleaning out of the elbow joint when she demanded of the orthopedic surgeon that he perform an osteotomy as well to straighten her elbow. Against his better judgment, he agreed. Partially as a consequence of the osteotomy the patient suffered permanent stiffness and sued. The court held that in these circumstances it is incumbent on the doctor "to prove affirmatively that the effect of the sedation probably did not adversely affect the patient's understanding of the basic nature of the contemplated operation."⁴⁹ It was found that this consent had been voluntary, but the doctor was nevertheless held liable because the consent was not informed. A doctor in this

47. (1964) 53 D.L.R. (2d) 65 (Que. C.A.); see also Browne v. Lerner (1940) 48 Man. R. 126.

48. Supra n. 44.

49. Id. at 32.

position might be well advised to postpone the operation until he could fully discuss the matter with the patient.

(b) Patient Must Have Capacity

A consent will be valid only if given by a patient who has the legal capacity to give it.⁵⁰ Thus the consent of a minor or a person not mentally competent by reason of disease or the influence of alcohol or drugs may not be valid.

(i) Minors

A person under the age of majority⁵¹ can consent to medical treatment for his benefit provided that he is capable of appreciating fully the nature and consequences of the particular treatment.⁵²

Two Canadian cases illustrate the application of this principle. In Booth v. Toronto General Hospital⁵³ the issue of the 19 year old plaintiff's consent to throat surgery arose. Chief Justice Falcon-

50. See Frenkel, supra n. 40.

51. Note that the common law age of majority of 21 years has been reduced by legislation to eighteen years in Alberta, Manitoba, Ontario and Quebec and to nineteen years in British Columbia, Saskatchewan and Nova Scotia.

52. Nathan, supra n. 22 at 176. See Bowker, Legal Liability to Volunteers Testing New Drugs (1963) 88 Can. Med. Assn. J. 745; see also Gilborn, supra n. 3 at 376.

53. (1910) 17 O.W.R. 118 (K.B.).

bridge assessed the plaintiff in these terms:⁵⁴

He is not of the highest intelligence, but it appears that he was nineteen years of age and capable of taking care of himself.

On the issue of whether this minor was capable of consenting to the treatment or not he said:⁵⁵

The only question of law involved was whether the boy's parents should have been consulted, but that was effectively answered, and it has been shewn that he is capable of doing a man's work. Indeed, he is at present doing hard work for 10 hours a day.

The plaintiff's action was dismissed.⁵⁶

The plaintiff was twenty years of age in the second case, Johnston v. Wellesly Hospital.⁵⁷ He consented to treatment for acne by a duly qualified specialist in dermatology. Addy J., looking at whether the consent of the plaintiff's parents or guardian was required, said:⁵⁸

Although the common law imposes very strict limitations on the capacity of persons under 21 years of age to hold, or rather to divest themselves of, property or to enter into contracts concerning matters other than necessities, it would be ridiculous in this day and age, where the voting age is being reduced generally to 18 years, to state that a person of 20 years of age, who is obviously intelligent and as fully capable of understanding the possible con-

54. Id. at 120. Note that the age of majority was twenty-one.

55. Id. at 120.

56. Falconbridge, C.J. said id., that he might have entered a nonsuit against the plaintiff but he felt, in view of the attack on the defendant hospital, that the true story should be brought out.

57. (1970) 17 D.L.R. (3d) 139 (Ont. H.C.).

58. Id. at 144. Note that the age of majority was twenty-one.

sequences of a medical or surgical procedure as an adult, would, at law, be incapable of consenting thereto. But, regardless of modern trend, I can find nothing in any of the old reported cases, except where infants of tender age or young children were involved, where the Courts have found that a person under 21 years of age was legally incapable of consenting to medical treatment. If a person under 21 years were unable to consent to medical treatment, he would also be incapable of consenting to other types of bodily interference. A proposition purporting to establish that any bodily interference acquiesced in by a youth of 20 years would nevertheless constitute an assault would be absurd.

This test, which has been variously described as "Lord Nathan's Test",⁵⁹ "the emancipated minors test"⁶⁰ or the "mature minor rule",⁶¹ requires a subjective assessment of the patient. It would be ludicrous to require parental consent for treatment of a seventeen year-old employed full time, living away from parents and supporting himself, or for a pregnant sixteen-year-old living with her husband. Both would be mature minors capable of giving consent.

In order to provide more certainty, legislation has been passed in some jurisdiction and proposed in others.⁶² Quebec passed the Public Health Protection Act⁶³ in 1972 which states that care may be pro-

59. Supra n. 22.

60. See, for example, Rozovsky, Consent to Treatment (1973) 11 Osgoode Hall L.J. 103.

61. See, for example, Wadlington, Minors and Health Care: The Age of Consent (1973) 11 Osgoode Hall L.J. 115.

62. For a more detailed discussion see Picard, Recent Developments in Medical Law (1977) 3 Leg. Med. Q. 201; see also Wadlington, id.; Family Law Reform Act (Imp.) 1969, c. 46, s. 8. See Skegg, Consent to Medical Procedures on Minors (1973) 36 Mod. L. Rev. 370. See also Hewer v. Bryant [1969] 3 All E.R. 578 (C.A.).

63. Public Health Protection Act, 1972 (Que.), c. 42, s. 36. See Joyal-Poupard, La notion de danger et la protection des mineurs (1976) 36 Rev. du Bar. 495; Crepeau, Le Consentement Du Mineur au Matiere De Soin et Traitements Medicaux ou Chirurgicaux Selon Le Droit Civil Canadien (1974) 52 Can. Bar Rev. 247.

vided by a hospital or physician to a minor fourteen years of age or older. But if the minor is sheltered for more than twelve hours or if there is extended treatment, the person having parental authority must be informed.

In 1973 British Columbia took action by the addition of a new section to the Infants Act⁶⁴ which provides that the age of consent to medical treatment be sixteen years. During debate, an amendment added a subsection making the minor's consent effective only if "a reasonable effort" has been made to give parental consent, or in lieu thereof, if a written opinion is obtained from another practitioner that the treatment is in the best interests of the minor. The physician is empowered to inform the parent that the minor has been treated.

Ontario sought a partial solution by Regulations under the Public Hospitals Act permitted surgical operations and other treatment in hospitals with the consent of a person of sixteen years, or one who is married.⁶⁵

Other provinces are looking at the problem⁶⁶ and recommendations have come from the Institute of Law Research and Reform in Alberta⁶⁷

64. R.S.B.C. 1960, c. 193, s. 23 [en. 1973, c. 43, s. 1]. For a criticism see Gosse, Consent to Medical Treatment: A Minor Digression (1974) 9 U.B.C.L. Rev. 56.

65. Supra n. 13.

66. See Picard, supra n. 62.

67. Alberta Institute of Law Research and Reform, Report No. 19, Consent of Minors to Health Care (1975).

and the Uniform Law Conference.⁶⁸

The arbitrary setting of an age from which consent is valid is common to all of the proposed legislative reform. But a problem may still exist for the doctor whose patient is under that statutory age yet needs health care for a problem such a drug or alcohol abuse or the prevention or termination of pregnancy,⁶⁹ and cannot or will not obtain parental consent. The removal of a minimum age for treatment of these problems would be a reasonable step reflecting an understanding of and concern for contemporary youth.⁷⁰

If a patient does not satisfy the "mature minor" test and is not covered by statute the doctor ought to obtain the consent of a parent or guardian to treatment.⁷¹ Some concern has been expressed about the situation where the person purporting to consent is neither parent nor guardian but merely has the child in his care or is in loco parentis, for example the school teacher who brings an injured child to a doctor for treatment. In many of these cases the doctor will be justified in proceeding because there is an emergency, or because he has a bona fide belief that the adult has been vested with authority by

68. Medical Consent of Minors Act, Uniform Law Conference of Canada Proceedings, 57th Annual Meeting 162. The Uniform Act is now law in New Brunswick: Medical Consent of Minors Act, 1976 (N.B.), c. M-6.1.

69. For an excellent discussion of the specific problem of prescription of contraceptives to minors, see Gilborn, supra n. 3.

70. See Alta I.L.R.R., supra n. 67.

71. Skegg, supra n. 62.

the parent or guardian,⁷² but in some cases resort to the courts might be necessary with the assistance of provincial social service departments.

Where the minor has capacity to give consent, it is valid and ought not to be overridden by an adult's decision to the contrary.

(ii) Adults with a disability

An adult who is not of sound mind cannot give a valid consent.⁷³ If he has been so declared by a court order there will have been someone appointed who can consent on his behalf.⁷⁴ Some patients under psychiatric treatment may not be competent to consent and a written report should be obtained from a psychiatrist whenever the doctor is in doubt. In some provinces the psychiatric hospital is vested with power by legislation⁷⁵ to consent for treatment of the patient both within that facility and for medical care in general.

It is not necessary to obtain the consent of a spouse for treatment to the other.⁷⁶ This is true even where the procedure involved is therapeutic sterilization. While some authors state that obtaining the

72. See Tompkins, Health Care for Minors: The Right to Consent (1974-75) 40 Sask. L. Rev. 41.

73. See Frenkel, supra n. 39.

74. See Dependent Adults Act, supra n. 39.

75. See, for example, Mental Health Act 1972 (Alta.), c. 118, as amended, ss. 24, 25, 26 [re-en. 1973, c. 76, s. 4], 53.

76. Speller, Law of Doctor and Patient 36 (1973).

consent of a spouse to a procedure which takes away the capacity for procreation would be advisable,⁷⁷ there is no Canadian or English authority for the proposition that a person deprived of the right to have children by a spouse could claim damages from the doctor.⁷⁸

Prisoners have the same right to accept or refuse medical treatment as any other person.⁷⁹

(c) Patient Must be Informed⁸⁰

The patient needs information before he can make a decision whether or not to consent. However the process is a bilateral one in which both the patient and the doctor have the right to knowledge of critical facts and the duty to respond in a way appropriate to their roles. So while the patient has the right to be told of the risks of treatment, he has a corresponding duty to apprise the doctor of the specifics of

77. Rozovsky, supra n. 12 at 41; Speller, id. at 38.

78. Medical Defence Union, supra n. 14 at 9. If a court did so, it would in these times of equality of the sexes have to hold that a wife must consent to the sterilization of her husband.

79. Bowker, Experimentation on Humans and Gifts of Tissue: Articles 20-23 of the Civil Code (1973) 19 McGill L.J. 161 at 177; for an interesting example of the misuse of authority by prison officials see Leigh v. Gladstone (1909) 26 T.L.R. 139 (K.B.), a case involving force feeding of women prisoners.

80. For a full discussion see Castel, Nature and Effects of Consent with Respect to the Right to Physical and Mental Integrity in the Medical Field: Criminal and Private Law Aspects (1978) 16 Alta. L. Rev.; Picard, supra n. 24.

his complaint and to cooperate in establishing essential facts.⁸¹

The doctor has the right to be told everything, including that which might be irrelevant; he must decide what information may be eliminated and then must elicit such further information as he thinks material. He is now in a position to exercise his duty to inform the patient of the risks involved in the treatment he, in his professional judgment, recommends.

It is now up to the patient to unequivocally communicate to the doctor his decision to accept or reject the proposed treatment.⁸²

This knowledge does not show precisely which risks need be revealed to the patient. The amount of information necessary to satisfy the requirement that consent be "informed" will now be discussed.

It is important to note at the outset that although Canadian courts have espoused the American term "informed consent", our jurisprudence in the area is much different.⁸³

In the United States, two standards for the scope of information required now exist, each with its own following. As a result, there is a great deal of confusion there over informed consent,⁸⁴ in spite of a "spate of legal articles unequalled in the history of [American]

81. Note that this might include the patient's asking questions: Smith v. Auckland Hospital Bd. [1965] N.Z.L.R. 191 (C.A.).

82. For cases where the patient fell short see Nykiforuk v. Lockwood [1941] 1 W.W.R. 327 (Sask. D.C.); Boase v. Paul *supra* n. 31.

83. For a discussion of the American law see Plante, An Analysis of "Informed Consent" (1968) 36 Fordham L. Rev. 639.

84. Id. See also Louisell & Williams, Medical Malpractice, Matthew Bender, New York, 1969.

medicolegal jurisprudence,"⁸⁵ and both the legal and medical professions are frustrated over the state of the law.⁸⁶

One standard employed is the "full disclosure" standard,⁸⁷ which requires that all risks be revealed. The patient's full knowledge is the goal, whether that is medically sound or not. However, the doctor need only give an explanation which would be understood by a "reasonable" patient;⁸⁸ the test of the patient is objective and no account need be taken of any patient's peculiar deficiencies.

The other standard is also the one used in Canada, the "professional disclosure" standard, which requires that a doctor disclose only the risks that his colleague would normally disclose with respect to the treatment in question.⁸⁹ But the doctor must take into account the particular patient's intellectual and emotional characteristics, as well as the relationship between himself and the patient, the patient

85. Epstein & Benson, The Patient's Right to Know (1973) 47 J. Am. Hosp. Assn. 47.

86. See Maldonado, Strict Liability and Informed Consent: Don't Say I Didn't Tell You So (1976) 9 Akron L. Rev. 609.

87. Canterbury v. Spence (1972) 464 F. 2d 772 (U.S.C.A. D.C. Ct.); Cobbs v. Grant (1972) 502 P. 2d 1 (Cal. C.A.). For a comprehensive list see Seidelson, Medical Malpractice: Informed Consent Cases in "Full Disclosure" Jurisdictions (1976) 14 Duquesne L. Rev. 309, wherein it is stated that this standard results in better communication between doctor and patient and better health care.

88. Canterbury v. Spence id. at 787; Cobbs v. Grant id. at 11-12.

89. Note that the doctor has a duty to answer the patient's questions fully and honestly. This may result in the inquisitive patient being told more. Smith v. Auckland Hospital Bd. *supra* n. 81.

test for this standard being a subjective one.⁹⁰ The classical statement of the standard is found in Smith v. Auckland Hospital Board,⁹¹ brought into Canadian law by Male v. Hopmans.⁹²

As it seems to me, the paramount consideration is the welfare of the patient, and given good faith on the part of the doctor, I think the exercise of his discretion in the area of advice must depend upon the patient's overall needs. To be taken into account should be the gravity of the condition to be treated, the importance of the benefits expected to flow from the treatment or procedure, the need to encourage him to accept it, the relative significance of its inherent risks, the intellectual and emotional capacity of the patient to accept the information without such distortion as to prevent any rational decision at all, and the extent to which the patient may seem to have placed himself in his doctor's hands with the invitation that the latter accept on his behalf the responsibility for intricate or technical decisions. Finally, it cannot be overlooked that although the patient may not appreciate the specific risk in the particular treatment, he has lived like all of us with the knowledge that contingencies are inseparable from human affairs, and accordingly would recognise, without being told, that there can be no part of medical practice which is infallible. Even when some warning may seem necessary, however, I cannot think that there should be an inevitable elaboration of detailed risks. Nor can it be sufficient to show after the event that a doctor would have been wiser to say more. This duty appears to be governed by all the factors I have mentioned as they would be assessed and applied by a reasonably prudent medical practitioner; and the need to include descriptions of the adverse possibilities of treatment in the explanation must depend upon the significance which that prudent doctor in his patient's interests would reasonably attach to them in all the environment of the case. I certainly am not prepared to hold in the absence of authority, that doctors should be distracted from their prime responsibility to care for the health of their patients by the thought that there is an almost automatic need to describe these possibilities in order to avoid a claim in negligence should something, by bad chance, go wrong.

90. Koehler v. Cook (1975) 65 D.L.R. (3d) 766 at 767 (B.C.S.C.). See also Kenny v. Lockwood *supra* n. 5 where the patient was "a woman of education"; Mulloy v. Hop Sang *supra* n. 38 where the patient was "a Chinaman without much education".

91. [1964] N.Z.L.R. 241; reversed [1965] N.Z.L.R. 191 (C.A.).

92. (1966) 54 D.L.R. (2d) 592 at 597-598 (Ont. H.C.).

Here then are the factors to be borne in mind by a doctor when deciding what to tell his patient:

- (1) the gravity of the condition
- (2) the benefits of the treatment
- (3) the probability and nature of any risks
- (4) the intellectual and emotional characteristics of the patient
- (5) the degree of dependency in this doctor-patient relationship.

Note that the above is based on certain assumptions: that the doctor places the patient's welfare first, and acts in good faith,⁹³ and that the patient realizes that medical science is not infallible, and that hindsight is clearer than foresight.

Some more specific guidelines emerge from the cases. It is not necessary to explain risks "inseparable from any option, such a failure or death under an anaesthetic, the danger of infection, of tetanus, of gas gangrene or gangrene.....,"⁹⁴ to tell of details "calculated to frighten or distress the patient"⁹⁵ nor to tell of risks that are extremely remote, for example, one in a thousand.⁹⁶ The actual medical techniques need not be explained in detail "as long as the nature of the treatment is fully understood."⁹⁷

93. Kenny v. Lockwood *supra* n. 5 at 525.

94. Id. at 523; see also McLean v. Weir *supra* n. 9.

95. Kenny v. Lockwood *id.* at 525.

96. McLean v. Weir *supra* n. 9.

97. Johnston v. Wellesley Hospital *supra* n. 57 at 145. Further, there is no need to explain that it is the first operation done since the doctor qualified; Lepp v. Hopp (1979) 8 C.C.L.T. 260 (Alta. C.A.).

In summary:⁹⁸

In ordinary medical practice the consent given by a patient to a physician or surgeon, to be effective, must be an "informed" consent freely given. It is the duty of the physician to give a fair and reasonable explanation of the proposed treatment including the probable effect and any special or unusual risks. [emphasis supplied].

Certainty in the Canadian law of informed consent has been achieved through the marriage of the professional standard of disclosure with the subjective test of the patient. This union balances the interests of the medical practitioners and their patients: while the professional disclosure standard is less onerous on the doctor, he still has the burden of proving that it was satisfied; and the patient, protected by the subjective test, can expect to have risk material to him explained in a way that he can understand.⁹⁹ The rampant chaos over consent in the United States can be avoided here.

(d) Consent Must be Referable to Both the Treatment and the Person Who is to Administer It

(i) Consent to the Treatment

It is in the best interest of both the doctor and the patient that they both understand the limits of the consent. The essence of consent is an agreement by the patient to accept the specific risks involved,

98. Halushka v. University of Sask. (1965) 52 W.W.R. 608 at 615 (Sask. C.A.).

99. Note that it is also easier for him to prove causation should the action be in negligence. See infra.

so it is important that he receive only the treatment to which he has consented. Should more extensive or difficult treatment be rendered, then apart from circumstances of emergency, the patient might be successful in bringing suit against the doctor, even if the unauthorized treatment was beneficial.

The test used in Canada is whether the patient has consented to the general nature of the treatment. If so, then such sub-procedures or variations of the treatment as are reasonable or in common practice would also be covered.¹⁰⁰ In a recent case, Gorback v. Ting,¹⁰¹ indicates that a patient has the right to choose procedures where more than one is medically feasible. In that case, an anesthetist was held liable for injuries to a patient's teeth and bridge work following an attempted administration of general anaesthetic. The decision was based partially in the finding that although there was no evidence that medical considerations required a general, the patient was not given the option of choosing a local anaesthetic.

Most problems in this area have arisen in cases where the communication between doctor and patient prior to treatment has been inadequate or ambiguous, resulting in the doctor's believing that consent has been obtained for something when in fact it has not.

100. Male v. Hopmans supra n. 92; Johnston v. Wellesley Hospital supra n. 57. Caron v. Gagnon (1930) 68 Que. S.C. 155; LaFrenier v. Hôpital Maisonneuve [1963] Que. S.C. 467.

101. Gorback v. Ting [1974] 5 W.W.R. 606 (Man. Q.B.). See also Kangas v. Parker [1976] 5 W.W.R. 25 (Sask. Q.B.), where it was held that a dental patient should have been given the choice of a hospital or the dentist's office and a general or local anaesthetic.

The most extreme case is Schweizer v. Central Hospital,¹⁰² in which a patient who entered hospital expecting an operation on his great toe instead received a spinal fusion. While the doctor had received approval for both procedures from the Workman's Compensation Board, the consent form signed by the patient made no reference to a spinal fusion. The patient was adamant that back surgery was never discussed, and the trial judge found the doctor's recollection of the facts wholly defective. This, combined with conflicting evidence in the hospital records, contributed to the finding of liability against this doctor.

Two lesser cases of extending treatment beyond that for which consent was given are Parmley v. Parmley¹⁰³ and Boase v. Paul.¹⁰⁴ In both cases the defendant dentist removed all the upper teeth under general anaesthetic. In the former case consent was given only for the removal of two teeth, and in the latter case, for one tooth. The dentist in Parmley was held liable but liability was escaped in Boase, only because the limitation period had expired.

If the communication of consent is faulty because the patient has given unclear instructions, the medical practitioner might not be held liable. Two such cases, again involving dentists, are Nykiforuk v. Lockwood,¹⁰⁵ where the patient wanted two upper molars extracted but

102. Supra n. 13.

103. Supra n. 33.

104. Supra n. 31.

105. Nykiforuk v. Lockwood supra n. 82.

appeared to the dentist to have indicated the two lower ones, and Guimond v. Laberge¹⁰⁶ where the patient replied "Oui" to the dentist's query "Toutes des dents, Madame Guimond?" even though she meant only the upper teeth. The actions were dismissed in both cases, it being held that the patient consented to the treatment given.

The above examples all emphasize the point that the best protection of both the doctor's and the patient's interests is the obtaining of an unequivocal consent from the patient for the treatment to be administered.

(ii) Consent to the person administering treatment

Consent is personal and normally authorizes a specific person to carry out the specific treatment. Where the doctor or hospital employee to whom the consent is given proceeds directly with the procedure or treatment on the conscious patient, it is not difficult to find an implied consent to the individual. It is more difficult where the patient has been anaesthetized. The consent forms used by many hospitals anticipate this situation and provide for it; for example, one modern form recommended for use in Canada states:¹⁰⁷

I, (Name of Patient) of (City, town) hereby consent to submit to the following procedure, operation or treatment...to be performed

106. (1956) 4 D.L.R. (2d) 559 (Ont. C.A.).

107. Rozovsky, supra n. 12 at 44. Note that this form is signed by both the patient and the doctor. For other variations see Meredith, supra n. 42 at 149; Medical Defence Union, supra n. 14 at 15.

by such members of the (Name of Hospital) medical staff or employee as required and with the assistance of such employees of the (Name of Hospital) as required for the procedure, operation or treatment. [emphasis supplied]

It is certainly in the doctor's and hospital's best interest to provide for a consent to the group, i.e. medical staff or employees. This is particularly true in teaching hospitals where house staff may be performing certain procedures. On the other hand a patient who chose and entrusted his life to a particular doctor ought to have the right to have that doctor treat him. The obvious answer might seem to present the group consent form to the patient and if he refuses to sign it, then to use the named doctor form instead, but this presupposes an informed and strong-willed patient. A better suggestion would be to use the group consent to cover admission, processing and day to day care, and use the named doctor form for any surgery or high-risk tests. The patient is assumed to know that the doctor engaged to do the surgery will not also be administering the anaesthetic; in fact there is support¹⁰⁸ for the proposition that the doctor has implied authority to engage another to administer the anaesthetic.

5. Experiments

Any treatment outside of the usual or common practice requires a broader disclosure of the risks by the doctor than is usually re-

108. Villeneuve v. Sisters of St. Joseph [1971] 2 O.R. 593 (Ont. H.C.); Burk v. S., B., and K. (1951) 4 W.W.R. 520 (B.C.S.C.).

quired. The extent to which the disclosure must exceed the normal requirements depends upon the potential effect of the experiment upon the patient. The label "experimentation" covers a great range of scientific activity. Advancing a slim hope of remission to a patient suffering from a terminal disease by testing a new drug¹⁰⁹ is quite different from administering a new anaesthetic to a paid subject who will obtain no benefit apart from the financial one.¹¹⁰

Where treatment is experimental or investigative but of possible benefit to the patient he is entitled to "complete disclosure" of the risks and a higher standard of care is expected of the doctor.¹¹¹ There are so few modern Canadian cases on point, that the exceptions, if any, to this general statement are a matter of speculation.¹¹² It would seem reasonable that the doctor be allowed to withhold information about a risk from a patient who would benefit greatly from the new treatment but whose recovery might be adversely affected if he knew the risk. Hence the term "complete disclosure", which would allow room for exceptions, is used rather than "full" disclosure.

However, where the experimentation is of the research type and of little or no benefit to the subject the full disclosure standard is

109. Bowker, supra n. 52.

110. Halushka v. University of Sask. supra n. 98.

111. Cryderman v. Ringrose [1977] 3 W.W.R. 109; affirmed [1978] 3 W.W.R. 481 (Alta. C.A.). Bowker, supra n. 52; Baills v. Boulanger (1924) 4 D.L.R. 1083 (Alta. C.A.), where it was held that a physician was entitled to use an ultraviolet lamp which was still experimental at that time.

112. See Rozovsky, Informed Consent and Investigational Drugs (1977) 3 Leg. Med. Q. 162.

required. A clear statement of the law is found in Halushka v. University of Saskatchewan¹¹³ where the subject, a student, was paid fifty dollars to participate in the test of a new anaesthetic. He was told that the test was safe "and there was nothing to worry about", but was not told that the experiment involved a new drug, that there were risks, and that a catheter would be advanced towards his heart. He signed a consent form which purported to release the doctors from liability for accidents. During the test he suffered a cardiac arrest, and later succeeded in an action against the doctors. Holding the consent to be ineffective, the court awarded damages of \$22,500 and said:¹¹⁴

There can be no exceptions to the ordinary requirements of disclosure in the case of research as there may well be in ordinary medical practice. The researcher does not have to balance the probable effect of lack of treatment against the risk involved in the treatment itself. The example of risks being properly hidden from a patient when it is important that he should not worry can have no application in the field of research. The subject of medical experimentation is entitled to a full and frank disclosure of all the facts, probabilities and opinions which a reasonable man¹¹⁵ might be expected to consider being giving his consent. [emphasis supplied]

The legal, ethical and scientific problems surrounding non-therapeutic human experimentation, particularly where minors, mental incompetents or prisoners are concerned, are far too complex to be

113. Supra n. 98. Note that this case was brought in tort as a battery case but could also have been brought in contract.

114. Id. at 616-617.

115. The use of a subjective test of the patient here, as in general medical treatment, would better protect the patient.

adequately dealt with in this thesis, but some of the difficult questions and attempted answers to them have been raised by Canadian authorities.¹¹⁶

The increasing frequency of human tissue transplants, like all advances in medicine, has created new challenges for the law, particularly in the area of consent. Most provinces have responded with legislation¹¹⁷ which provides for inter vivos gifts (i.e., gifts made while the donor is living) of organs, and allows a direction by an individual, or certain next-of-kin that after death his body or certain of his organs are to be made available for transplantation purposes.

Again, many hard issues beyond the scope of this thesis are being fought in this field, especially where minors and mental incompetents are involved.¹¹⁸

116. Bowker, supra n. 52; Bowker, supra n. 80; Waddams, Medical Experiments on Human Subjects (1967) 25 U.T.F.L. Rev. 25; Dickens, Information for Consent in Human Experimentation (1974) 24 U.T.L.J. 381; Dickens, The Use of Children in Medical Experimentation (1973) 43 Med. Leg. J. 166; Sharpe, The Minor Transplant Donor (1975) 7 Ottawa L. Rev. 85.

117. As amended: Human Tissue Gift Act, 1973 (Alta.), c. 71; Human Tissue Gift Act, 1972 (B.C.), c. 27; Human Tissue Act, R.S.M. 1970, c. H180; Human Tissue Act, R.S.N.B. 1973, c. H-12; Human Tissue Act, 1971 (Nfld.), No. 66; Human Tissue Gift Act, 1973 (N.S.), c. 9; Human Tissue Gift Act, 1971 (Ont.), c. 83; Human Tissue Gift Act, R.S.P.E.I. 1974, c. H-14; Human Tissue Gift Act, 1974 (Sask.), c. 47; Civil Code (Que.), arts. 20-23.

118. See the famous American decisions of Strunk v. Strunk (1969) 445 S.W. 2d 145 (Ky. C.A.), where authority for a transplant from a 27 year old mental incompetent to a 28 year old brother was granted, and Hart v. Brown (1972) 289 A. 2d 386 (Conn. S.C.) where approval was given to a transplant between eight year old twins. See also Sharpe, supra n. 116; Castel, Some Legal Aspects of Human Organ Transplant (1968) 46 Can. Bar Rev. 345. See also special provisions relating to minors and mental incompetents in some of the legislation listed id.

A doctor involved in experimentation or transplantation ought to seek a legal opinion founded on the particular fact situation, with reference to relevant statutory material.

6. Remedies

A survey of the case law indicates that where a consent is deficient an action may be brought against the doctor in either battery or negligence. While some courts have made strong statements emphasizing the need to differentiate between the two actions, others have apparently ignored the difference. Recent cases show the importance of this distinction. The important practical consequences of the choice in the areas of onus of proof expert evidence, proof of damage, causation, limitation periods, and insurance coverage have already been discussed.¹¹⁹

(a) Negligence

Kenny v. Lockwood,¹²⁰ Male v. Hopmans,¹²¹ and Gorback v. Ting¹²² are all cases in which an action for failure to adequately inform a patient before obtaining his consent was framed in negli-

119. Supra Chapter 3.

120. Supra n. 5.

121. Supra n. 92.

122. Supra n. 101.

gence. Only in Gorback v. Ting was liability found on this ground. However, the important point is that no mention of battery was made in any of these cases.

(b) Battery

A greater number of cases have proceeded on the more traditional basis of trespass to the person,¹²³ and a number of them have carefully distinguished this from the negligence action. In Marshall v. Curry, the trial judge said of the two actions:¹²⁴

The action is not one of negligence or malpractice, but one of assault and battery. The operation, if unlawful, was technically a surgical battery for which the defendant is liable. "The distinction ordinarily between an unauthorized operation amounting to assault and battery on the one hand, and negligence such as would constitute malpractice, on the other, is that the former is intentional, while the latter is unintentional:" Hershey v. Peake (1924), 115 Kan. 562.

An even more decisive statement was made by Addy J. in Johnston v. Wellesley Hospital:¹²⁵

123. Murray v. McMurchy supra n. 32; Mulloy v. Hop Sang supra n. 38; Turner v. Toronto Gen. Hospital Trustees [1934] O.W.N. 629 (H.C.); Schweizer v. Central Hospital supra n. 13; Koehler v. Cook supra n.90.

124. Supra n. 17 at 276.

125. Supra n. 57 at 144.

The question of consent, of course, is very relevant to the case because, if there was no legal consent, the treatment administered by the doctor would constitute an actionable assault, the question of negligence would not enter into consideration.... [emphasis supplied]

Similarly, in Halushka v. University of Saskatchewan¹²⁶ the court distinguished between the two actions by stating that the failure to give a full explanation relates to battery, not negligence.

In a dramatic decision in 1976, Kelly v. Hazlett,¹²⁷ Morden J. created a dichotomy between the battery and negligence actions. He said that if there is no informed consent to the basic nature and character of the medical treatment the proper action is battery, but if there is no informed consent to the collateral risks the proper action is negligence. In the case before him the doctor had failed to inform the patient of the risk of stiffness after an osteotomy. This risk the judge found to be a collateral one, and held the doctor liable in negligence. The author has commented on the practical and theoretical difficulties of the distinction elsewhere, as have others.¹²⁸ At best it would seem to further burden the medical profession by requiring the classification of risks as "basic" or "collateral" to treatment. In a case decided very shortly afterward, Reibl v. Hughes¹²⁹ the risk

126. Supra n. 98.

127. Supra n. 44.

128. See Picard, supra n. 24; see also Klar, Annotations to Kelly v. Hazlett supra n. 44 and to Lepp v. Hopp supra n. 43.

129. (1977) 78 D.L.R. (3d) 35 (Ont. H.C.). On appeal a new trial was ordered. (1977) 6 C.C.L.T. 227 (Ont. C.A.).

of a stroke from an internal carotoid endarterectomy was characterized as both basic and collateral. Thus there was liability in battery, but Haines J. found negligence too in the failure to make clear the purpose of the operation, and in the failure to explain the risk of stroke.

Kelly v. Hazlett was referred to by Brennan J. at trial in Lepp v. Hopp,¹³⁰ and he discussed liability solely in terms of battery. However the majority of the Alberta Court of Appeal found liability in both battery and negligence and the dissenting justice treated the case as a negligence action.

By contrast, in a case¹³¹ pleaded in negligence the Ontario Court of Appeal nevertheless cited Kelly v. Hazlett and dealt with the question of whether the risks taken were basic to the nature and character of the surgery. However, the dichotomy raised in Kelly v. Hazlett was not utilized, nor did the court remark upon it.¹³² It remains to be seen whether the distinction set out in Kelly v. Hazlett will continue to be ignored or become a new pattern for the action where the patient

130. (1977) 2 C.C.L.T. 1983; reversed (1979) 8 C.C.L.T. 260 (Alta. C.A.).

131. Chipp v. Peters (1976) Brooke J., unreported (Ont. C.A.).

132. See also McLean v. Weir supra n. 9 which was decided one year after Kelly v. Hazlett supra n. 44 but neither cited it nor distinguished between battery and negligence.

has not given adequate consent to treatment.¹³³

Communication between doctor and patient is at the center of the consent issue, and indeed, is part of the therapy of medicine.¹³⁴ While full disclosure is neither necessary nor desirable, full bilateral communication between doctor and patient is: the failure of breakdown of communication between doctor and patient lies at the bottom of most law suits against doctors.¹³⁵

133. For a comment see Stevenson J. in Cryderman v. Ringrose supra n. 111 at 119-120. In the U.S. there has been a move away from battery to negligence as the proper basis. See Plante, supra n. 83, McCoid, A Reappraisal of Liability for Unauthorized Medical Treatment (1950) 41 Minn. L. Rev. 381. Note also that a criminal prosecution may be justified: see R. v. Maurantonio (1967) 65 D.L.R. (2d) 674 (Ont. C.A.) where a conviction for indecent assault was upheld when a man posing as a doctor examined six women; see also Bolduc v. R. (1967) 63 D.L.R. (2d) 82 (S.C.C.), where a doctor examined a woman with a friend present who posed as a doctor. The two were acquitted because the doctor's examination was proper and the friend's presence was not an assault.

134. McLean v. Weir supra n. at 108.

135. This fact is repeated in the annual reports of both the Canadian Medical Protective Association and the Medical Defence Union. See also McLean v. Weir id.

CHAPTER V

NEGLIGENCE

1. Introduction

The law of negligence is emphasized in this thesis because it governs the majority of actions brought against hospitals and doctors and other health care professionals. While the general principles are easily stated, an understanding of their application is more difficult to acquire. This is especially so in the typical medical negligence case because it involves members of an honourable calling, the exercise of professional judgment and technical skills, and a body of complex scientific knowledge. Each case requires a decision on its unique facts and, therefore close attention to precedents and adherence to the doctrine of stare decisis is often of less value to a judge than it is in some other kinds of cases.¹ However, as certain a statement of the law as is possible will be of value both to lawyers who require a basis on which to advise clients and prepare cases, and to doctors and hospitals who need to understand the legal standards against which their conduct is to be measured. This chapter and the two following attempt to satisfy this need.

1. See Crits v. Sylvester (1956) 1 D.L.R. (2d) 502 at 508; affirmed [1956] S.C.R. 991.

2. Basics of Negligence

To be successful a negligence action must meet four requirements:²

- (a) the defendant must owe the plaintiff a duty of care
- (b) the defendant must breach the standard of care established by law
- (c) the plaintiff must suffer an injury or loss
- (d) the defendant's conduct must have been the actual and legal cause of the plaintiff's injury.

If the case fails to meet any of these requirements, then the action will be dismissed; therefore each of the above will now be considered in more detail.

(a) Duty

A pre-condition to any discussion of standard of care, or any of the other elements of the negligence action, is the finding that the defendant owed a duty of care to the plaintiff. If it cannot be shown that there was a duty upon this particular defendant to exercise care with respect to this particular plaintiff, there can be no finding of liability, regardless of how "negligent" the defendant's conduct may appear.³

2. See supra Chapter 3.

3. For a detailed discussion of the use and abuse of the duty concept in negligence law see Smith, The Mystery of Duty in Studies in Canadian Tort Law (2d ed. Klar 1977).

The duty of a doctor to exercise care with respect to a particular patient springs into being upon the formation of the doctor-patient relationship⁴ and therefore the issue in medical negligence cases tends to be concerned less with the existence of the duty than with its scope. The scope of a duty is closely related to the standard of care, and Part 3 of this chapter analyzes the standard of care involved in the exercise of the doctor's most important duties.

The duty placed on the doctor is to exercise care in all that he does to and for the patient, which includes attendance, diagnosis, referral, treatment and instruction.⁵ The nature of each of these facets of duty, together with its attendant standard of care are also discussed in detail in Part 3.

In many cases, for example where a patient is hospitalized, the doctor is not the only professional who owes a duty to the patient, and in certain circumstances the doctor can, as the courts say, "rely"⁶ on the duty owed by the other professional. That is, the doctor's duty is suspended with respect to matters falling within the scope of the other professional's duty to the patient. Thus it has been held that in the operating room a surgeon can rely on the anaesthetist to perform his

4. See supra Chapter 2.

5. In the U.S. the duty has been extended to include a duty to warn third parties of a serious danger from a patient under treatment: Tarasoff v. Regents of University of California (1976) 131 Cal. Rptr. 14, 529 P. 2d 553 (Cal. S.C.). For a comment see Stone, The Tarasoff Decisions: Suing Psychotherapists to Safeguard Society (1976) 90 Harv. L. Rev. 358.

6. For a discussion of when he will be liable for the acts of others see Chapter 9.

tasks properly,⁷ the resident to close the incision⁸ and the nurse to count the sponges.⁹ (The doctor in charge at the time of closing has a duty to perform a final search for sponges, but the extent of the search required varies with the nature of the operation.)¹⁰ Hospital personnel may be relied upon to properly secure the patient for surgery¹¹ and in the recovery room the nurses' duty to the patient is paramount.¹² On the ward, the work of the nurses, doctors and others is established by hospital rules and practice and generally the doctor is entitled to assume competence on the part of these other participants in the patient's care. This is so even where dangerous drugs are involved. Where a patient died from an injection of adrenalin provided by a nurse in response to the doctor's request for Novocain, it was held that the doctor had no duty to check the label notwithstanding that his doing so would have prevented the death.¹³

However, there are limitations on the extent to which a doctor may rely on the duty of others. When he relinquishes the care of his

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7. Paton v. Parker [1941-42] 65 C.L.R. 187 (Aust. H.C.).
 8. Karderas v. Clow (1973) 32 D.L.R. (3d) 303 (Ont. H.C.).
 9. Jewison v. Hassard (1916) 10 W.W.R. 1088 (Man. C.A.); Meredith, Malpractice Liability of Doctors and Hospitals 80 (1957).
 10. Id. See also Van Wyck v. Lewis [1924] App. D. 438 (S. Africa C.A.).
 11. Knight v. Sisters of St. Ann (1967) 64 D.L.R. (2d) 657 (B.C.S.C.). See also Armstrong v. Bruce (1904) 4 O.W.R. 327 (Ont. H.C.) where a patient was burned with a hot water pad placed by a nurse during an operation.
 12. Laidlaw v. Lions Gate Hospital (1969) 70 W.W.R. 727 (B.C.S.C.); Kolesar v. Jeffries (1976) 59 D.L.R. (3d) 367 at 377 (Ont. H.C.).
 13. Bugden v. Harbour View Hospital [1947] 2 D.L.R. 338 (N.S.S.C.).

patient to others it is incumbent upon him to take steps for the patient's continued care. In a case where a patient was discharged from hospital with a supply of anticoagulant drugs¹⁴ it was held that the doctor could not rely on the resident to inform the patient of dangerous side effects, and that the doctor ought to have foreseen the action and had a duty to adequately instruct his patient.

The modern move to specialization sometimes creates a problem in this area. Whether the situation be a referral from a general practitioner to a specialist or from one specialist to another, a patient may have a number of doctors all believing erroneously that another is carrying out his duty to the patient. Each doctor then assumes that the other has discharged a duty such as explaining the risks of a dangerous test,¹⁵ or informing him of "factual data pertinent and necessary to diagnosis" and taking appropriate action,¹⁶ when in fact neither has done so, with disastrous consequences for the patient.¹⁷ In this situation too much care is preferable to too little, and failing the medical profession's developing a practice for the protection of the

14. Crichton v. Hastings [1972] 3 O.R. 859 (C.A.).

15. McLean v. Weir (1977) 3 C.C.L.T. 87 (B.C.S.C.) and Picard, Annotation.

16. Holmes v. Bd. of Hospital Trustees of London (1978) 5 C.C.L.T. 1 (Ont. H.C.) and Picard, Annotation.

17. Id., where there was a failure of both doctors to read or consult or obtain a report on cervical x-rays for five days while the patient's condition, an infection described as "retropharyngeal abscess" went undiagnosed. As a result the patient was rendered a quadriplegic.

patient the courts will be forced to do so.¹⁸

Therefore, where parts of medical care or treatment are normally the responsibility of others, those persons are alone accountable to the patient for any negligence with respect to those aspects of the treatment. But the fundamental and residual duty to the patient lies with the doctor.¹⁹ Another factor which promises to become more critical if consumerism in health care continues to grow, is the duty a patient owes to himself: to provide information, to follow instructions, and generally to act in his own best interests.²⁰

A doctor who refuses to treat a patient commits no breach of legal duty²¹ (although he may be in breach of his professional ethics), but upon the formation of the doctor-patient relationship, his duty exists until the clear severance of the relationship²² and includes the duty to take affirmative action, for example, where it is evident that a hip dislocation has been reduced by the treatment given and resetting is required.²³

18. See Anderson v. Chasney [1949] 4 D.L.R. 71 (Man. C.A.); affirmed [1950] 4 D.L.R. 223 (S.C.C.).

19. See Nathan, Medical Negligence 36-40 (1957); Rozovsky, Canadian Hospital Law 51 (1974).

20. Moore v. Large (1932) 46 B.C.R. 179 at 183 (B.C.C.A.); see also Bergstrom v. G. [1967] C.S. 513 (Que. S.C.).

21. Nathan, supra n. 19 at 37.

22. Pellerin v. Stevenson (1945) 18 M.P.R. 345 at 357 (N.B.C.A.); see also Hunter v. Ogden (1871) 31 U.C.R. 132 (Ont. H.C.) and supra Chapter 2.

23. Dangerfield v. David (1910) 17 W.L.R. 249 at 257 (Sask. S.C.).

(b) Standard of Care

Under our legal system every person is required to conduct himself in such a way as not to cause harm to others. The standard against which individuals are measured is that of the "reasonable man"²⁴ and conduct which fails to meet this standard and causes injury to another will render the wrongdoer liable to the person injured.

Persons who hold themselves out as possessing special skills or abilities must practise their art, profession or business²⁵ so as to meet a standard of conduct equivalent to that of a reasonably competent member of their group. Accordingly, the standard of care required of a doctor is "that of a reasonable medical man considering all the circumstances..."²⁶ The standard was formulated during the Roman era²⁷ and remains largely unchanged in modern times.²⁸

The law's expectation of the doctor have been described in more

24. Blyth v. Birmingham Waterworks (1856) 11 Exch. 781 (Ct. of Exch.); Donoghue v. Stevenson [1932] A.C. 562 (H.L.).

25. Lanphier v. Phipos (1838) 8 C. & P. 475, 173 E.R. 581 (Nisi Prius); R. v. Batemen (1925) 19 Cr. App. R. 8 (Ct. of Crim. App.).

26. Cryderman v. Ringrose [1977] 3 W.W.R 109 at 118 per Stevenson J.; affirmed [1978] 481 (Alta. C.A.). See also McCormick v. Marcotte [1972] S.C.R. 18 at 21.

27. Lex Aquilia 287 B.C. Digest 9.2.1.

28. Glos, Torts - Doctrine of Professional Negligence - Standard of Professional Care (1963) 41 Can. Bar Rev. 140. For example, Slater v. Baker (1767) 2 Wils. 359, 95 E.R. 860; Pippin v. Sheppard (1822) 11 Price 400, 147 E.R. 512 (Ct. of Exch.); Lanphier v. Phipos *supra* n. 25; Leighton v. Sargent (1853) 27 N.H.R. 460, 59 Am. Dec. 388 (N.H.S.C.); Rich v. Pierpont (1862) 3 F. & F. 34, 176 E.R. (Nisi Prius).

detail a follows:²⁹

The legal principles involved are plain enough but it is not always easy to apply them to particular circumstances. Every medical practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. He is bound to exercise that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing, and if he holds himself out as a specialist, a higher degree of skill is required of him than of one who does not profess to be so qualified by special training and ability.

Whether a defendant has met the requisite standard of care is a question of fact for the trial judge,³⁰ and one which lies at the heart of every negligence suit. As one Canadian authority has said:³¹

No court in a negligence suit can escape a decision about whether or not the defendant's conduct breached the standard of care fixed by law....The bulk of legal talent and judicial resources is expended on this matter.

(i) Proof of the standard

A judge or jury is in no position to compare the conduct of a doctor

29. Crits v. Sylvester supra n. 1 at D.L.R. 508 per Schroeder J.A. See also Cardin v. Montreal (1961) 29 D.L.R. (2d) 492 at 494 (S.C.C.) wherein it is made clear that the same standard applies in Quebec. See also Crepeau, La Responsabilité Civile du Médecin Et De L'Établissement Hospitalier 69 Wilson et La Fleur, Montreal, 1956. Crepeau, La Responsabilité Médicale et Hospitalière Dans La Jurisprudence Québécoise Récent (1960) 20 Rev. de Bar 433.

30. Czuy v. Mitchell [1976] 6 W.W.R. 676 at 678 (Alta. C.A.).

31. Linden, Canadian Tort Law 82 (1977). This book contains a broad outline and discussion of negligence law in Canada. See also Haines, The Medical Profession and the Adversary Process (1973) 11 Osgoode Hall L.J. 41 at 44; McCoid, The Care Required of Medical Practitioners (1959) 12 Vand. L. Rev. 549 at 614.

to that required of the "reasonable medical man"³² without expert evidence. The court needs such information in order to decide whether the defendant acted according to "approved practice," failed to meet the standard of care, or only made an "error of judgment."³³ The experts are usually doctors who practise the same speciality as the defendant or who are specialized in the medical area in issue.³⁴

The difficulties and peculiarities of proof in the medical negligence action are discussed in detail in Chapter VII.

(ii) The nature and character of the standard of care

The test of whether an individual's conduct meets the standard of the "reasonable person" is an objective test;³⁵ that is, no account is taken of the individual's own physical characteristics, intelligence or personality. In the context of medical negligence, the test of whether the doctor meets the standard of "normal, prudent practitioner" is also said to be objective, but most authorities³⁶ acknowledge that a

32. Sherman, The Standard of Care in Malpractice Cases (1966) 4 Osgoode Hall L.J. 222.

33. For a detailed discussion of these defences see infra Chapter 6.

34. See Wilson v. Swanson (1956) 5 D.L.R. (2d) 113 at 126 (B.C.C.A.) where the evidence of a doctor who fitted neither category was held to be inadequate.

35. Linden, supra n. 31 at 92.

36. Louisell and Williams, Medical Malpractice, Matthew Bender, New York, 1977 at 200-206; McCoid, supra n. 31 at 614.

subjective element is involved in the application of the test:³⁷

Thus in order to decide whether negligence is established in any particular case the act or omission or course of conduct complained of must be judged, not by ideal standards nor in the abstract but against the background of circumstances in which the treatment in question was given.

Thus the medical practitioner is measured objectively against a reasonable medical person who possesses and exercises the skill, knowledge and judgment of the normal, prudent practitioner of his special group. The comparison is made, however, with reference to the particular circumstances at the material time.³⁸ The inquiry into the doctor's milieu will fall into three broad categories:

- (a) the education, experience and other qualifications of the doctor
- (b) the degree of risk involved in the procedure or treatment
- (c) the equipment, facilities and other resources available to the doctor.

Each of the above will now be considered in turn.

A. Qualifications of the doctor

General practitioner and specialist. The standard of care expected of a doctor is directly related to his qualifications, and therefore a specialist is expected to possess and exercise a higher degree of skill

37. Nathan, supra n. 19 at 22-23.

38. Meredith, supra n. 9 at 62. For an excellent judicial treatment of these see Lieberman J. in Tiesmaki v. Wilson [1974] 4 W.W.R. 19; affirmed [1975] 6 W.W.R. 639 (Alta. C.A.).

in his particular field than would be expected of a general practitioner in that field.³⁹

If [a doctor] holds himself out as a specialist, a higher degree of skill is required of him than of one who does not profess to be so qualified by special training and ability.

The point is illustrated by a number of cases. While there was evidence that a specialist might in the circumstances have diagnosed gas gangrene, a general practitioner in a small town was held not liable for failing to do so.⁴⁰ Similarly, in a case where specialists called at trial were critical of a small town general practitioner's failure to diagnose carbon monoxide poisoning, the court held that the general practitioner was not negligent in the circumstances.⁴¹ In a case where it was shown that a pediatrician would have diagnosed epiglottitis in a child, another small town practitioner was held not negligent by failing to do so.⁴²

The difference in the standard of care required of general practitioners and specialists extends to treatment as well as diagnosis of course. In Wilson v. Stark,⁴³ two general practitioners in a small Saskatchewan centre who worked for over three hours in an unsuccessful attempt to locate and remove the patient's retrocecal appendix were held

39. Crits v. Sylvester *supra* n. 1; Wilson v. Swanson *supra* n. 34 at 119 *per* Rand J. and 124 *per* Abbott J.; Meredith, *supra* n. 9 at 62-63.

40. Challand v. Bell (1959) 18 D.L.R. (2d) 150 at 154 (Alta. S.C.).

41. Ostash v. Sonnenberg (1968) 63 W.W.R. 257 (Alta. C.A.).

42. Tiesmaki v. Wilson *supra* n. 38.

43. (1967) 61 W.W.R. 705 (Sask. Q.B.).

not liable although it was shown that a specialist would have had little difficulty.

There are areas where the standards of care for general practitioners and specialists are equivalent. One example is treatment of circulatory complications in fracture cases; it has been held that "there is a usual and normal practice in the profession, regardless of speciality, namely to split or bi-valve the cast."⁴⁴ It is probably no coincidence that this area has been the subject of many lawsuits involving patients who have suffered serious losses.⁴⁵

Once the court has determined the doctor's speciality it can, with the help of expert evidence, determine the appropriate standard of care.

Evidence of education (degrees, certificates and memberships, publications and privileges) and training (internship, residency, research and special study) provides formal and relatively objective criteria for establishing specialization status.⁴⁶ In general, the greater the education and training, the higher the standard expected. Evidence of extensive experience in a speciality will certainly raise the standard⁴⁷ and may even be a substitute for some of the formal criteria

44. Ares v. Venner [1970] S.C.R. 608 at 614-15 per Hall J. quoting the trial judge, approved in Vail v. MacDonald (1976) 66 D.L.R. (3d) 530 at 534 (S.C.C.).

45. As well as those discussed see Badger v. Surkan [1973] 1 W.W.R. 302 (Sask. C.A.); Van Mere v. Farwell (1886) 12 O.R. 285 (Ont. C.A.); Challand v. Bell *supra* n. 40 at 150; Vail v. MacDonald *id.*

46. MacDonald v. York County Hospital (1973) 41 D.L.R. (3d) 321 at 331 (Ont. C.A.) per Brooke J.A.; affirmed sub nom. Vail v. MacDonald *supra* n. 44; Eady v. Tenderenda [1975] 2 S.C.R. 599.

47. Johnston v. Wellesley Hospital (1970) 17 D.L.R. (3d) 139 at 141 (Ont.).

just mentioned.⁴⁸ But while the acquisition of experience by the doctor may raise the standard expected of him, a lack of experience will not lower it. A doctor may hold himself out as a specialist either by formal certification or by the more subtle means of gradually restricting his practice to a particular type of medical problem, patient or treatment,⁴⁹ and once he does so he will be expected to practise his profession at the standard of care required of the specialist. As one authority on tort law has explained, the problem is one of balancing the protection of society against the encouragement of beginners:⁵⁰

The skill demanded from beginners presents an increasingly difficult problem in modern society. While it is necessary to encourage them, it is equally evident that they cause more than their proportionate share of accidents. The paramount social need for compensating accident victims, however, clearly outweighs all competing considerations and the beginner is, therefore, held to the standard of those who are reasonably skilled and proficient in that particular calling or activity. [emphasis supplied]

Thus a doctor described as a "relatively novice surgeon" who had never before performed the particular operation was nonetheless held liable when he cut a nerve⁵¹ as was an anaesthetist performing a

48. In Fluevog v. Pottinger (1977) unreported (B.C.S.C.) one of the issues was whether the defendant dentist was to be judged as a specialist in prosthodontics. On the basis of his experience he was held to have to meet that standard, albeit that he had no formal certification as a specialist.

49. Id.

50. Fleming, The Law of Torts 110 (5th ed. 1977). This passage in other editions was quoted with approval in Challand v. Bell supra n. 40 at 152 and in McKeachie v. Alvarez (1970) 17 D.L.R. (3d) 87 at 100 (B.C.S.C.).

51. McKeachie v. Alvarez id.

trans-tracheal ventilation for the first time.⁵²

It ought to be noted that one of the classical statements of the standard of care does state that a doctor is to meet the standards of the "normal, prudent practitioners of the same experience and standing".⁵³ However, there is no authority for the use of this comment to support a lower standard for the inexperienced.⁵⁴

There is some suggestion that a higher standard might be expected from a doctor or dentist who holds a university teaching appointment⁵⁵ or from one who holds an administrative post such as a medical superintendent.⁵⁶ It would seem unreasonable to take this suggestion beyond its relevance to tasks within the normal competence of these positions. For example, to hold a general practitioner who is a medical superintendent of a hospital to higher standard by virtue only of his position does not seem reasonable.⁵⁷

The recognition of such informal criteria as experience, association with specialists, and hospital appointments to raise the standard, as well as the overlap of certain specialties has led to some difficulties

52. Holmes v. Bd. of Hospital Trustees of London *supra* n. 16. Note that there is no requirement that the patient be informed that the doctor is performing a procedure for the first time, Lepp v. Hopp (1979) 8 C.C.L.T. 260 (Alta. C.A.).

53. Crits v. Sylvester *supra* n. 1.

54. Dale v. Munthali (1977) 16 O.R. (2d) 532 (Ont. H.C.).

55. Kangas v. Parker [1976] 5 W.W.R. 25 at 47 (Sask. Q.B.).

56. Jarvis v. Internat. Nickel Co. [1929] 2 D.L.R. 842 at 847 (Ont. S.C.).

57. Id.

in the courts. Vail v. McDonald⁵⁸ is an illustrative case. The doctor had formal qualifications as a general surgeon, a fellowship, and fifteen years experience in general surgery. His practice was approximately sixty percent with traumatic injuries including "orthopedic work". He had hospital privileges in "emergency vascular problems". At issue was his treatment of a fractured ankle by performing a closed reduction which resulted in impaired circulation and the patient's loss of his foot. The trial judge held⁵⁹ that there had been no evidence that the defendant was qualified "to a higher degree than a general practitioner on the staff of a general hospital in the city" and applied the standard of the general practitioner.

In the Court of Appeal⁶⁰ one justice thought the relevant standard to be that of a general surgeon with "extensive training, experience and responsibility in orthopedic surgery" while the two others held the standard to be "greater than that of a general practitioner but less than a cardiovascular specialist." The Supreme Court of Canada held that the standard of care, whether that of a general practitioner, general practitioner with cardiovascular expertise, or general surgeon with orthopedic expertise, would be the same in regard to a circulatory problem.

In any event, each of the judges involved, after applying the standard he thought appropriate, found that the defendant failed to meet it.

58. Vail v. MacDonald *supra* n. 44. See also Sherman *supra* n. 32 at 230.

59. MacDonald v. York County Hospital *supra* n. 46 at 332-2.

60. Id. at 321.

In another case⁶¹ a doctor who it seemed had no special education, training or experience in surgery but who had joined the surgical department of a small clinic and said he had "minor surgical privileges and some major surgical privileges but none very major"⁶² was held to the standard of a surgeon.⁶³

In Chipps v. Peters and Shepherd, a general surgeon by education, training and experience removed the uterus of a patient and did "repair work to improve her bladder and to stop the protrusion of her vagina". Difficulties ensued and the patient brought action alleging that the doctor was negligent in undertaking gynecological surgery. Both the trial judge and the Court of Appeal accepted expert evidence that general surgeons have a role in performing this type of surgery, and there was also evidence that the defendant had done forty-eight hysterectomies and vaginal repairs. The defendant was held to have met the required standard of care, which was that of a general surgeon.⁶⁴

House staff and students. A member of the hospital's house staff (interns and residents) may be found negligent if he fails to meet the standard of care required, which is the average level of competence of the group to which he belongs. Hospitals and other institutions which take on house staff have basic educational requirements. The period of training and experience available varies in intensity and quality both

61. McKeachie v. Alvarez *supra* n. 50 at 87.

62. Id. at 89.

63. Id. at 101.

64. (1976) unreported (Ont. C.A.) Brooke J.A.

from hospital to hospital and according to the motivation of the individual student, and therefore the courts consider the education, stage of training and experience of these defendants.⁶⁵ The courts' consideration of these factors may result in the raising of the standard of care, but inadequacies in these factors will not shield house staff from the necessity of meeting the basic standard of the average level of competence.

The public interest in the proper training of future doctors must be balanced by the protection of the hospital patient who may not always be sure of the status of the "doctor" who is treating him, and house staff have been successfully sued on a number of occasions. In an early case⁶⁶ an intern performing a tonsillectomy accidentally removed the uvula. While both the trial judge and the appeal court were prepared to hold that this surgery did not meet the appropriate standard, the medical evidence was that there was no injury suffered by a child deprived of this part of her body, thus the requirement of injury was not satisfied and no liability followed. In another case⁶⁷ an intern performing an intravenous injection severed the tubing which then remained in the patient's vein. His failure to correctly position the patient's arm and to follow the written instructions accompanying the

65. Murphy v. St. Catherines Gen. Hospital (1964) 41 D.L.R. (2d) 697 at 703 (Ont. H.C.).

66. McNamara v. Smith [1934] 2 D.L.R. 417 (Ont. C.A.).

67. Murphy v. St. Catherines Gen. Hospital *supra* n. 65 at 697. Note that the hospital was also held liable for failing to supervise or instruct him. In addition, the hospital was liable for the negligence of the intern. See Chapter 10.

Intracath device was found to be negligence. A senior resident in anaesthesiology assisting an anaesthetist was held not to have met the high standard of care expected of a well-qualified resident who had assisted in twelve to fifteen "heart-lung pump operations". The hospital was held liable for his negligence⁶⁸ as was another hospital when a resident closing an incision did not explain how a sponge came to be left behind.⁶⁹

Fraser v. Vancouver General Hospital⁷⁰ is the leading decision on the standard of care expected of house staff. Following an accident the patient was examined in the emergency ward by two interns who took x-rays and interpreted them. They decided that there was nothing abnormal and so advised a general practitioner by telephone, although the patient continued to complain of a stiff neck. The patient was discharged and eventually died with what was later diagnosed as a dislocated fracture of the neck. All three courts held that the interns had failed to meet the requisite standard of care by reading the x-rays incorrectly and by not calling the radiologist who was available. The case pointed out some expectations unique to the standard of care as it applies to house staff. Rand J. of the Supreme Court of Canada said that the intern:⁷¹

68. Aynsley v. Toronto Gen. Hospital (1969) 7 D.L.R. (3d) 193 (Ont. C.A.); [1972] S.C.R. 435 upholding the Court of Appeal as to the resident only since the anaesthetist did not appeal.

69. Karderas v. Clow *supra* n. 8

70. [1952] 2 S.C.R. 36.

71. Id. at 46.

...must use the undertaken degree of skill, and that cannot be less than the ordinary skill of a junior doctor in appreciation of the indications and symptoms of injury before him, as well as an appreciation of his own limitations and of the necessity for caution in anything he does.

Interns and residents are normally employees of the hospital and therefore it is the institution which must pay any judgment arising out of the negligence of the house staff.⁷²

No cases against the medical undergraduate student involved in clinical medical school programs have been reported.⁷³ These so-called "student-interns" are now found in many Canadian hospitals and it is likely that a standard of care analogous to that for doctors and house staff will be developed for this group.

It is clear that the courts expect students of the profession at all stages to exercise caution against their own inexperience.

Non-doctors. The layman who undertakes a task requiring the professional services of a doctor will be expected to meet the standard of care appropriate to a doctor.⁷⁴ So where a chiropractor represented that he possessed special skill and knowledge with regard to human ailments generally it was held that he had to meet the standard of a general practitioner. He did not, because he made no diagnosis and his treatment injured the patient, and he was held liable.⁷⁵

72. Id. at 36; Karderas v. Clow supra n. 8.

73. No English cases have been reported either. Speller, Law of Doctor and Patient 82 (1973).

74. Nathan supra n. 19. See also Sherman supra n. 32 at 229.

75. Gibbons v. Harris [1924] 1 D.L.R. 923 (Alta. C.A.). A Chiropractor is the same as a medical doctor or osteopath for the general principles of law. Penner v. Theobald (1962) 40 W.W.R. 216 (Man. C.A.).

B. Degree of risk involved

As the degree of risk involved in a certain treatment or procedure increases, so rises the standard of care expected of the doctor. The principle was expressed succinctly as follows:⁷⁶

The degree of care required by the law is the care commensurate with the potential danger...

However, the doctor must have known, or ought to have known of the risk⁷⁷ at the material time, which is the time at which the procedure or treatment took place. The doctor's actions of yesterday are not judged in light of what no one knew until today. An illustrative and famous English case is Roe v. Minister of Health,⁷⁸ in which two men became paralyzed after the administration of spinal anaesthetic. The Nupercaine used was stored in glass ampules in a phenol solution, which percolated into the Nupercaine via invisible cracks in the ampoules. This risk of contamination was unknown in 1947, the time of the accident, but by 1951 warnings were in a leading textbook. When the case was heard in 1953, it was held that the standard of medical knowledge in 1947 was the test, and the anaesthetists were found to have met that standard.

76. Badge v. Surkan (1970) 16 D.L.R. (3d) 146 at 153; affirmed [1973] 1 W.W.R. 302 (Sask. C.A.).

77. Nathan, supra n. 19.

78. [1954] 2 Q.B. 66 (C.A.).

However, a doctor who is found to have had knowledge of a risk and does not meet the higher standard established as a result will not face a sympathetic court.

In a case where a patient who was "suffering from epilepsy with post-epileptic automation" and a "tendency to irresponsible moving about...well known to all concerned."⁷⁹ jumped from his fourth floor window, it was found that the defendant neurologist was the one most fully aware of the danger of the patient's injuring himself. The court held that in failing to take special precautions for the patient's supervision the defendant did not meet the high standard of care expected of him.⁸⁰

In terms of the standard of care expected when there is knowledge of a risk, potential risks can be distinguished on the basis of the degree to which their presence will raise the standard of care. At one end, representing those risks whose presence will most dramatically effect an increase in the standard of care are procedures of an experimental nature; at the other end are risks associated with more common procedures, which generally have less effect on the standard of care.

The highest standard of care is expected of the doctor using a new or experimental procedure or treatment.⁸¹ It is no coincidence that

79. University Hospital Bd. v. Lepine [1966] S.C.R. 561 at 570 per Farthing J. at trial.

80. University Hospital Bd. v. Lepine (1965) 53 W.W.R. 513 (Alta. C.A.). Note that the Supreme Court of Canada reversed the finding of joint liability of the doctor and the hospital on the basis that the patient's action in jumping from the window was not foreseeable.

81. Cryderman v. Ringrose *supra* n. 26 at 109.

it is in these circumstances that the patient is entitled to a full explanation of all risks.⁸² There are not enough cases of experimental medical treatment to allow for specificity with respect to this high standard or how it may be met. However, assuming that uncertainty begets caution, this may be a desirable state of affairs.⁸³

A high standard of care is also expected where drugs are in use, especially where the potential injury is substantial.⁸⁴ In a case where massive doses of neomycin were administered and the defendant surgeon failed to follow the manufacturer's recommended tests for hearing loss, the surgeon was held to be negligent in causing the patient's permanent deafness.⁸⁵ A dermatologist was similarly held liable for failing to monitor a patient's use of a drug known as chloroquine (Aralen), and for failing to detect changes in her condition until permanent injury had occurred.⁸⁶

82. Halushka v. University of Sask. (1965) 53 D.L.R. (2d) 436 (Sask. C.A.). See supra Chapter 4.

83. Cryderman v. Ringrose supra n. 26 at 117; Crossman v. Stewart (1977) 5 C.C.L.T. 45 (B.C.S.C.).

84. Crichton v. Hastings supra n. 14. For a discussion on tort liability for drugs see Linden, Tort Liability for Defective Drugs (1977) 1 Leg. Med. Q. 169; Lenczner, Who is liable? The Investigator? The Medical Doctor? The Health Protection Branch? (1977) 1 Leg. Med. Q. 174.

85. Male v. Hopmans (1966) 54 D.L.R. (2d) 592; varied 64 D.L.R. (2d) 105 (Ont. C.A.).

86. Crossman v. Stewart supra n. 83. Note that the patient was held to be two-thirds at fault for obtaining the drug without a prescription for part of the time. See infra Chapter 6.

Surgery and anaesthesiology may give rise to identifiable risks which will raise the standard of care. In a case where the anaesthetist did not completely shut off the oxygen flow, the patient was seriously burned in an explosion set off by a static spark.⁸⁷ The court said:⁸⁸

When, as here, the anaesthetist was handling a dangerous substance...and he knew of the hazard...the degree of care required from him was proportionately high and he was bound to take special precautions to prevent injury to his patient. The very high degree of care which is to be exercised by persons who handle dangerous substances is well established and has been authoritatively laid down in the...cases....

In another case, the patient suffered serious and permanent injury during open heart surgery when the anaesthetist failed to see to the proper closing of a stopcock and air passed from the manometer through the transducer to the patient's venous system.⁸⁹ The court found negligence on the basis of the doctor's knowledge of the risk, coupled with his failure to close the stopcock properly or to detect his error quickly. Both the anaesthetist and the resident were held liable.

Many surgical procedures carry with them potentially serious risks which, fortunately, rarely materialize. This was illustrated in an action against an orthopedic surgeon⁹⁰ who during a disc operation lacerated and bruised the aorta and the vena cava causing the patient's

87. Crits v. Sylvester [1956] S.C.R. 991.

88. Crits v. Sylvester *supra* n. 1 at 511.

89. Aynsley v. Toronto Gen. Hospital *supra* n. 68.

90. Chubey v. Ahsan [1976] 3 W.W.R. 367 (Man. C.A.).

death. All surgeons recognized the need for special care in this surgery because of the danger of such injury. While the judge at trial and the majority of the Court of Appeal found the doctor was not negligent, the Chief Justice of the latter court wrote a strong dissenting judgment. The trial judge, Solomon J., had said:⁹¹

Despite the great risk of damage to the aorta artery during disc surgery, such damage rarely happens because of the care taken by orthopedic surgeons. According to statistics only one aorta is damaged in seven thousand disc operations and only 50 per cent of such damage to aorta results in death.

To which the dissenting Chief Justice replied:⁹²

Every surgeon, and more particularly every orthopedic surgeon, is fully aware that in this kind of operation there is a risk or damage to the aorta. How does he avoid that risk? The answer is, by taking due care. If in 7,000 operations of this kind, 6999 are performed without damage to the aorta one may safely conclude that the surgeons attained this happy result by the exercise of due care. What can successfully be done in 6,999 cases ought to have been done also in the 7,000th. That it was not done in the 7,000th case must be ascribed to lack of due care. Solomon J. called it misadventure. I call it negligence. I would accordingly hold the doctor liable.

A possible conclusion from this case is that the maintenance of a consistently high standard of care by a speciality may shield a doctor on a single occasion of sub-standard practice.

Occasional risks present only in a few patients are the least likely to affect the standard of care required. However, the standard of care will be raised in these situations where the doctor has, or ought to

91. [1975] 1 W.W.R. 120 at 124 (Man. Q.B.).

92. Supra n. 90 at 370.

have, knowledge of the particular risk. An example is the risk of gangrene in fracture case:⁹³

When in a particular case the danger of gangrene occurring is greater than in the case of an ordinary simply fracture, such calls for the exercise of great vigilance.

Therefore, to summarize, the risk reasonably perceived defines the standard required.⁹⁴

C. Resources

All the statements⁹⁵ of the standard of care contemplate that the court consider the circumstances in which the allegedly negligent treatment occurred. For the purposes of this discussion, circumstances are dealt with under two separate headings: i) facilities, and ii) equipment. The discussion under "facilities" concerns itself with the physical environment in which the treatment is administered, such as a roadside, private home or hospital. The section on "equipment" deals not only with the actual devices and instruments available but also methods and technology. Included is an analysis of the effect of an urban as opposed to a rural locality on the standard of care.

93. Supra n. 76.

94. Palsgraf v. Long Island Ry. Co. (1928) 248 N.Y. 339 per Cardozo J. Although he was speaking about negligence in general, his words apply to medical negligence.

95. See supra.

The categories of facilities, equipment and locality are obviously not mutually exclusive and some of that which is applicable to any one of them may be applicable to the others as well.

Facilities. In Alberta, Saskatchewan and Newfoundland, a doctor or nurse who voluntarily and gratuitously provides emergency treatment where there are inadequate facilities is protected by legislation which reads as follows:⁹⁶

3. Where, in respect of a person who is ill, injured or unconscious as the result of an accident or other emergency,

(a) a physician or registered nurse voluntarily and without expectation of compensation or reward renders emergency medical services or first aid assistance and the services or assistance are not rendered at a hospital or other place having adequate medical facilities and equipment, or

(b) a person other than a person mentioned in clause (a) voluntarily renders emergency first aid assistance and that assistance is rendered at the immediate scene of the accident or emergency,

the physician, registered nurse or other person is not liable for damages for injuries to or the death of that person alleged to have been caused by an act or omission on his part in rendering the medical services or first aid assistance, unless it is established that the injuries or death were caused by gross negligence on his part.

The scenario of the professional as a Good Samaritan rendering assistance at the site of a motor vehicle accident was undoubtedly in the minds of the well-intentioned legislators. No Canadian cases invol-

96. Emergency Medical Aid Act, R.S.A. 1970, c. 122, s. 3 [am. 1975(2), c. 26, s. 82(2)]; Emergency Medical Aid Act, 1971 (Nfld.), No. 15, s. 3; Emergency Medical Aid Act, 1976 (Sask.), c. 17, s. 3. Note that the nurse and lay persons are provided for in the same way. For a thorough discussion of the Good Samaritan statutes in the U.S., see Louisell and Williams, supra n. 36 at 594.

ving the statutes have been reported⁹⁷ and therefore any remarks regarding its legal effect are speculative to a degree.

Whether the situation could be described as an "accident or other emergency" or the facilities as "inadequate" would probably be decided according to the judgment of a reasonable doctor in the same circumstances. The statute is not intended to prevent compensation, and therefore if the doctor were to subsequently receive payment for his services he would not necessarily lose the protection of the legislation as a result. His evidence that he was not providing care with compensation in mind would probably be sufficient.⁹⁸

A person injured in these circumstances (or if he has died, his estate) who wished to sue the doctor would have to prove gross negligence. A satisfactory determination of what constitutes gross negligence has thus far eluded the courts. The law reports contain frequent judicial attempts to define it in the other two contexts in which it appears in Canadian law: gross negligence must be proven to hold a host driver liable to a gratuitous passenger, and to hold a municipality liable for damage resulting from the accumulation of ice or snow on a sidewalk.⁹⁹ The Supreme Court of Canada has said that gross

97. For a survey of the opinion of Ontario doctors, see Gray and Sharpe, *Doctors, Samaritans and the Accident Victim* (1973) 11 *Osgoode Hall L.J.* 1. The recent surveys showed that 90% of Ontario doctors would stop to assist whereas 50% of U.S. doctors would not. Note that in some European countries it is a crime for any person to fail to render aid in these circumstances.

98. Louisell and Williams, *supra* n. 36 at 594.

99. Linden, *supra* n. 31 at 120.

negligence means "very great negligence."¹⁰⁰ Stated another way, this means that a doctor will be held liable for only marked departures from the standard of care which in realistic terms, has the effect of lowering the standard required in these situations.

The importance of the statute ought not be over-emphasized. While it has the potential of applying in a variety of situations, there are difficulties in predicting its effect and with the concept of gross negligence. No Canadian doctor and very few American doctors have been sued in such situations and therefore such legislation appears to have been an over-reaction to a non-existent problem¹⁰¹ and in the event the traditional benevolence shown by the law under the normal rules of negligence to those who take affirmative action would more than adequately shield the doctor in these situations.¹⁰² Finally, the statutes exist in only three provinces.

Medical negligence law has shown itself to be sensitive to the difficulties of the doctor in inadequate facilities. Early on a cold December morning a general practitioner in Manitoba¹⁰³ was forced to examine a man in a truck because the patient was extremely intoxicated and would not move. Because of the absence of adequate facilities he

100. Studer v. Cowper [1950] S.C.R. 450.

101. Markus, Good Samaritan Laws: An American Lawyer's Point of View (1975) 10 Rev. Jur. Themis 29 at 31; Monaghan, Emergency Services and Good Samaritans (1975) 10 Rev. Jur. Themis 21; McIsaac, Negligence Actions Against Medical Doctors (1976) 24 Chitty's L.J. 201.

102. Henderson and Fisk, The Legal Position of a Doctor in Treating Accident Victims (1969) 24 Chitty's L.J. 224.

103. Rodych v. Krasey [1971] 4 W.W.R. 358 (Man. Q.B.); see also Hampton v. Macadam (1972) 22 W.L.R. 31 (Sask. D.C.).

failed to diagnose extensive damage to the chest, ribs and lungs. The court held that he had met the appropriate standard of care. In another case¹⁰⁴ where the facilities were more than adequate, the standard was not raised above that expected of the reasonable general practitioner. The patient was a prisoner who suffered a "blow-out fracture of the orbit of the eye" in a recreational hockey match. The trial judge said:¹⁰⁵

On considered of the whole of the evidence, no inference can be made that Dr. Webb did or omitted to do anything that an ordinary reasonably skilled practitioner would have done under the circumstances. In fact, there is no evidence that any general practitioner, possessing the normal equipment that would be available even at Joyceville Institution, which equipment is far superior to that which a general practitioner would normally have, and being given the information or complaints at the various material times that the Plaintiff gave to Dr. Webb, would have diagnosed the injury caused to the Plaintiff.

Thus, the courts will assess the adequacy of the facilities available to a doctor and adjust the standard of care downward if they are inadequate, but there is no authority that the availability of superior facilities has the opposite effect. A general practitioner might have privileges at a hospital equipped for sophisticated ophthalmological examination but it would be unjust to expect him as a consequence to meet a higher standard of care when treating problems of the eye.¹⁰⁶

104. Bell v. R. (1973) 44 D.L.R. (3d) 549 at 550 (Fed. Ct. T.D.).

105. Id. at 553.

106. He might, however, be under a duty to refer the patient to a specialist who could use the better facilities: see infra. See also McCormick v. Marcotte supra n. 26.

When there is a choice of facilities the doctor's election must be guided by the best medical interests of the patient. The consequences of a self-serving choice by a dentist arose in a recent case.¹⁰⁷ The patient was a healthy twenty-eight year old who required the extraction of a number of teeth. The dentist had an arrangement with an anaesthetist who did out-patient anaesthesiology in a nearby office, and told the patient to appear on a certain day at the anaesthetist's office. No history was taken nor was a physical examination carried out. The patient died of asphyxia while under general anaesthesia when he inhaled his own blood during the dental extraction.

The evidence showed that the patient was given no choice between having the extraction performed in the office or in a hospital, where proper preliminary examinations would have been required and where an emergency such as arose could have been handled. Both the anaesthetist and the dentist were found negligent on a number of grounds, including the arbitrary choice by the dentist of the most convenient facilities for himself without regard for the interests of the patient. As to the anaesthetist the trial judge said:¹⁰⁸

I find...that the Defendant Asquith's conduct had fallen far below the high standard of care required of an anaesthetist. It seems that the quality of work had been sacrificed for the quantity of patients that could be processed assembly-line style.... It is not required of a specialist that he warrant that his treatment will be successful. He is bound to exercise only that degree of care and skill which could reasonably be expected of a normal prudent practitioner of the same experience and standing. The...conduct in this case varied so drastically from the methods always used and followed by the other anaesthetists...before embarking on an operation, that it constitutes to my mind glaring negligence.

107. Kangas v. Parker *supra* n. 55.

108. Id. at 50.

On the more mundane level of the facilities, the evidence also showed that the anaesthetist had no telephone list of doctors who could be called upon to assist in an emergency, and precious seconds were lost in the attempt to locate a telephone number.

As was stated earlier,¹⁰⁹ the doctor is entitled to rely on others to assist him with the treatment of a patient. Whether they are colleagues, nurses or other health care personnel the doctor is entitled to assume that each is competent and will meet the standard of care required in carrying out his customary professional duties.¹¹⁰

Innovations in equipment. In this section we are concerned not only with "tools"¹¹¹ (implements and devices) but also with "techniques" (methods and procedures). The issue involved is the effect had on the standard of care when a new tool or technique comes into use by some members of the profession but not by all.

In this situation the law must balance the desirability of promoting advances in medical technology against the need to caution against resorting too rapidly to novel and untested treatment. This was recognized by a court years ago in these words:¹¹²

109. See infra s. II. A. of this Chapter.

110. See supra.

111. This includes drug therapy. See Parsons v. Schmok (1975) 58 D.L.R. (3d) 623 (B.C.S.C.).

112. McQuay v. Eastwood (1886) 12 O.R. 402 at 408 (C.A.). For a case where a doctor was unsuccessfully sued for his failure to prescribe drug therapy of questionable value see Parsons v. Schmok id.

I think a reckless disregard of a new discovery, and an adhesion to a once approved but exploded or abandoned practice resulting in injury to a patient would give a cause of action. But, on the other hand, no medical man can be bound to resort to any practice or remedy that has not had the test of experience to recommend it, and a physician or surgeon resorting to such new practice or remedy with injurious consequences following, would be more liable to an action than one who with like result followed the beaten track. Without experiment there would be no progress in medical or any other science.

Thus the doctor need not employ the very latest tools or techniques to meet the standard of care but neither can he ignore them once they have found their way into common use.¹¹³ The cases to be discussed show that, during the transition period, a doctor electing the older method will have his conduct carefully scrutinized by the courts.

Tremendous advances have occurred in medical technology. In these times of the C.A.T. scan (computer augmented tomograph) it is hard to believe that just over one hundred years ago doctors were practising blood letting.¹¹⁴ Yet many inventions now taken for granted were innovations a short time ago. A doctor was sued in 1932 for failing to x-ray a patient's shoulder after she had suffered a fall.¹¹⁵ The court held that the doctor met the standard of care by taking the usual tests even though they did not show the dislocation, which an x-ray would have. The Court of Appeal said:¹¹⁶

113. For a further discussion of the defences available to a doctor who is following the common practice see infra Chapter 6.

114. See Kelly v. Dow (1860) 9 N.B.R. 435 (S.C.) where the issue centred around whether the doctor had met his standard of care in bleeding the patient's arm.

115. Moore v. Large *supra* n. 20.

116. Id. at 182-183.

...there is no suggestion of any unskillfulness or want of care on his part except that of his failure to advise an x-ray. The two eminent specialists called for the defendant at the trial approved the defendant's diagnosis and stated that x-ray ought not to be advised in cases where the surgeon is convinced by the use of the usual tests that that course was unnecessary. It has not surely come to this that if the cause of the trouble is not apparent to the eye of the surgeon or physician he must advise an x-ray or take the consequences to his reputation and to his pocket for not having done so. Is the x-ray to be the only arbitrator in such a case and are years of study and experience to be cast aside as negligible? [emphasis supplied]

Fifty-six years later, it is hard to imagine a doctor failing to take an x-ray under the same circumstances and relying instead solely on study and experience.¹¹⁷

As indicated by the quote, expert evidence from other doctors as to equipment in common use is relied on by the court when determining the standard of care. However where in the opinion of the court, the tools or technique used indicate that the standard is too low, the court has the discretion to hold that a higher standard involving the use of superior tools or techniques is required.

This substitution of a lay judicial opinion for an expert medical one is not common but may occur in situations where the ordinary person is competent to judge, for example, where the taking of precautions is the issue. Such a situation arose in Chasney v. Anderson¹¹⁸ where a surgeon removing a child's adenoids did not avail himself of either of two techniques for assuring that sponges were not overlooked. The

117. See Parkin v. Kobrinsky (1963) 46 W.W.R. 193 (Man. C.A.); Hôpital Notre Dame de L'Esperance v. Laurent [1978] 1 S.C.R. 605; Price v. Milawski (1977) 1 L.M.Q. 303 at 308 (Ont. C.A.).

118. Supra n. 18. Nathan, supra n. 19 at 26. See also Holt v. Nesbitt [1951] 4 D.L.R. 478; affirmed [1953] 1 D.L.R. 671 (S.C.C.).

evidence was that in some hospitals these techniques were used but not in all. The Supreme Court of Canada agreed with the Court of Appeal of Manitoba where the Chief Justice had said:¹¹⁹

The practice of medicine and surgery is a progressive science. Experience has shown in the past the danger of leaving foreign substances in the cavities after an operation....It is not sufficient for the surgeon to say: "I never adopted the use of either of such precautions in operations of this nature." By doing so he took an unnecessary risk, as both were available for his use on that occasion and he assumed full responsibility for the lack of use of the same, and I would hold that he was negligent in doing so.

The decision shows that the standard of care is set by the court; expert testimony as to what the average doctor does is relevant but not conclusive. Where there are precautionary measures available, albeit not by common practice, a court may raise the standard of care accordingly.

The situation of precautionary measures and lay opinion aside, generally the doctor is not expected to use the very latest equipment¹²⁰ as shown by a dramatic English case.¹²¹ A patient was told he had inoperable cancer, and with the belief that he had not long to live he severed all ties with England and embarked for the U.S. where he was diagnosed as having chronic cystitis. Surgery revealed a condition of benign prostrate hypertrophy but no cancer. He sued the English doctor on the basis that the doctor had not met the standard by failing

119. Id. at 75; Elder v. King [1957] Que. Q.B. 87 (C.A.).

120 This was a true statement even in 1930. See Antoniuk v. Smith [1930] 2 W.W.R. 721 at 726 (Alta. C.A.).

121. Whiteford v. Hunter [1950] W.N. 553, 94 S.J. 758 (H.L.).

to verify the diagnosis by a cystoscopic examination. However, the House of Lords held that there was no liability saying that, while the type of cystoscope required was in common use in the U.S., it was rare in England at the time and the standard of care did not require the doctor, who did not possess one, to use it.

Where the use of an older tool or technique is not negligence per se, the availability of new methods may raise the standard of care required when using the older method. In a case¹²² where a doctor performed a mastoid operation using a surgical loupe and a chisel, the patient suffered facial paralysis and underwent a second operation by a different doctor who used more modern tools, a microscope and a dental drill. The Supreme Court of Canada found the first doctor negligent, not for the use of the older method, but for exercising less skill than that of which he was capable. He knew that better vision could have been had with a microscope than with a surgical loupe, and thus ought to have exercised more care when checking for bone chips.

So far the discussion has been with respect to tools or techniques which enjoy some use but are not yet universally employed. The effect on the standard of care by the use of either an avant-garde or obsolete method is more certain.

A doctor who uses an obsolete method does not meet the standard of care.¹²³ In 1970 a doctor applied a metal plate to a patient's broken leg when a specialist had advise skin traction followed by the insertion

122. Eady v. Tenderenda *supra* n. 46 at 26.

123. McCormick v. Marcotte *supra* n. 26 at 18.

of an intramedullary nail. The Supreme Court of Canada held that the doctor had not met the standard of care by using a method which had fallen into disfavour. On the other hand, a doctor who chooses to treat with the latest equipment or the newest techniques must meet a higher standard of care. In an older Alberta case¹²⁴ a patient alleged that he had suffered burns from treatment with a quartz lamp. The majority held that because the properties of the instrument were not at the time fully known or understood, it was incumbent on the doctor to exercise very great, if not the greatest care, possible in its use.¹²⁵

Similarly, an Ontario doctor who failed to follow the instructions accompanying a relatively new type of catheter or seek guidance was found to be negligent.¹²⁶ Naturally the doctor ought to avail himself of any available assistance from his colleagues when employing new tools or techniques, and of course ought not to deviate from the approved practice of handling an innovation. An anaesthetist's inexperience and failure to follow the inventor's suggestions when attempting transtracheal ventilation were the basis for a finding of negligence against him.¹²⁷ In summary, the standard of care is higher both for the doctor who uses a very new tool or technique and also for the doctor who continues to use an older one after his more progressive colleagues have moved to new approaches.¹²⁸

124. Bails v. Boulanger [1924] 4 D.L.R. 1083 (Alta. C.A.).

125. Id. at 1100.

126. Murphy v. St. Catherines Gen. Hospital *supra* n. 65.

127. Holmes v. Bd. of Hospital Trustees of London *supra* n. 16.

128. Nathan, *supra* n. 19 at 26 and 28.

Locality rule. The geographic location of the doctor's practice may have some bearing on the facilities, equipment and staff available to him when treating the patient. Whether the locality ought to affect the standard of care expected is an issue which has been dealt with in various ways by the courts.

The early history of Canada and the U.S. saw vast differences in facilities, equipment and assistants between the rural and the urban practitioner.¹²⁹ The situation was aggravated by prohibitive distances between the place of treatment and large centres, and by the often serious nature of disease and injury in those times. Recognition of these differences was taken in the U.S. in Tefft v. Wilcox,¹³⁰ the first enunciation of the locality rule, which is commonly stated as follows:¹³¹

A physician...by taking charge of a case, impliedly represents that he possess, and the law places upon him the duty of possessing, that reasonable degree of learning and skill that is ordinarily possessed by physicians and surgeons in the locality where he practices...

The effect of the locality rule was to compensate for the rural practitioner's disadvantages by lowering the standard of care expected

129. Waltz, The Rise & Gradual Fall of the Locality Rule in Medical Malpractice Litigation (1968) 18 De Paul L.R. 408 at 410.

130. (1870) 6 Kan. 46; for other early statements of the rule see Smothers v. Hanks (1872) 34 Iowa 286, 11 Am. Rep. 141 (Iowa S.C.); Hathorn v. Richmond (1876) 48 Vt. 557.

131. Pike v. Honsinger (1898) 155 N.Y. 201 at 209, 49 N.E. 760 at 762 (N.Y.C.A.).

of him; the standard became such that the measure was not the "same locality" but a "similar locality."¹³²

Canadian courts also made the adjustment to the standard of care, beginning with Zirkler v. Robertson:¹³³

It surely cannot be that the skill of a physician, attending a patient in a private house with few conveniences, and no assistants, is to be measured by the same standard as the city surgeon, provided with an operating room, assistants, nurses and all the aids of a modern hospital.

For a time the rule in Canada evolved similarly to that in the U.S., and later Canadian decisions indicate the use of the American phrase "same or similar locality."

The locality rule enjoyed acceptance in Canada up to 1960¹³⁴ but the jurisprudence was not consistent, and it was suggested in an early case¹³⁵ that the standard was not to be automatically lowered for the rural practitioner, but rather an "allowance" ought to be made "for particular circumstances of position."¹³⁶ The reasoning which was

132. Mann, (1975) 28 Vand. L. Rev. 441 at 442; Waltz, supra n. 129 at 411.

133. (1897) 30 N.S.R. 61 at 70 (C.A.); see also Hodgins v. Banting (1906) 12 O.L.R. 127 (H.C.). The case of Town v. Archer wherein the locality rule was soundly rejected was referred to as authority for removing the case from the jury. The comments of Falconbridge C.J. against the rule (infra n. 137) seem to have been ignored.

134. Wilson v. Swanson supra n. 34 at 124 per Abbott J.; Challand v. Bell supra n. 40; Meredith, supra n. 9 at 63.

135. Turriff v. King (1913) 9 D.L.R. 676 at 678 (Sask. S.C.) per Brown J.

136. Beven on Negligence 1156 and 1161 (3d ed. 1908) quoted in Turriff v. King id.

eventually accepted in Canada was stated in Town v. Archer:¹³⁷

It has been held in some American cases that the locality in which a medical man practises is to be taken into account, and that a man practising in a small village or rural district is not to be expected to exercise the higher degree of skill of one having the opportunities afforded by a large city; and that he is bound to exercise the average degree of skill possessed by the profession in such localities generally. I should hesitate to lay down the law in that way: all the men practising in a given locality might be equally ignorant and behind the times, and regard must be had to the present advanced state of the profession and to the easy means of communication with, and access to, the large centres of education and science.

Reference to the locality rule in Canadian medical negligence suits was not common after 1960¹³⁸ but three recent cases may indicate its revitalization in Canada.

In McCormick v. Marcotte¹³⁹ where a general practitioner was held liable for the permanent partial incapacity suffered by his patient after the general practitioner used an obsolete technique in an orthopedic operation, the Supreme Court of Canada said:¹⁴⁰

The medical man must possess and use, that reasonable degree of learning and skill ordinarily possessed by practitioners in similar communities in similar cases. [emphasis supplied]

137. (1902) 4 O.L.R. 383 at 388 (Ont. K.B.).

138. See, for example, Male v. Hopmans *supra* n. 85; Pederson v. Dumouchel (1967) 72 Wash. 2d 73 (Wash. S.C.); Douglas v. Bussabarger (1968) 73 Wash. 2d 476; Brune v. Belinkoff (1968) 235 N.E. 2d 793 (Mass S.C.). See also Waltz, *supra* n. 129 at 413; (1969) 44 Wash. L.R. 505; Frankel, Varying Standards of Care in Medicine (1970) 19 Clev. St. L.R. 43; McCoid, *supra* n. 31.

139. [1972] S.C.R. 18.

140. Id. at 21.

This was approved in Rodych v. Krasey¹⁴¹ by Matas J., who also mentioned and approved Challand v. Bell¹⁴² and Wilson v. Swanson.¹⁴³ His judgment seems to be founded on an application of the locality rule although he backed off somewhat from the narrowness of the rule:¹⁴⁴

In the case at bar I find that the plaintiffs have not discharged the onus upon them to show that [the defendant] was negligent under the particular circumstances obtaining at the time....[emphasis supplied]

Lieberman J. of the Trial Division of the Supreme Court of Alberta, in a thorough and careful judgment delivered in Tiesmaki v. Wilson¹⁴⁵ quoted¹⁴⁶ the locality rule as stated in Wilson v. Swanson¹⁴⁷ and Meredith,¹⁴⁸ and based his decision on its application to the case before him:¹⁴⁹

141. Supra n. 103.

142. Supra n. 40.

143. [1956] S.C.R. 804, 5. D.L.R. (2d) 113.

144. Rodych v. Krasey supra n. 103 at 371.

145. Supra n. 38.

146. Id. at 44.

147. Supra n. 143.

148. Supra n. 9.

149. [1974] 4 W.W.R. 19 at 48.

On the facts...I find that Dr. Wilson...acted in his...professional capacity within the standards laid down in the cases I have cited. Specifically I find "that [he] possessed and used that reasonable degree of learning and skill ordinarily possessed by practitioners in similar communities in similar cases": Wilson v. Swanson

The decision, including the application of the locality rule, was affirmed by the Appellate Division.¹⁵⁰

The advantages and disadvantages of the rule are worthy of some examination. While the rule protects the rural physician, probably a general practitioner, working under adverse conditions, this seems to be the only argument for its retention. On the other hand, the evils that result from rigid application of the locality rule have been paraded in many articles and cases from the United States.¹⁵¹ The number of witnesses available to either litigant is limited by the need for the witness to be from or familiar with practice "in the same or similar community". Physicians from the same community might be biased in favour of the defendant and the standard he represents. Courts have even been bogged down in debates about whether Miami is a community similar to West Palm Beach!¹⁵² Furthermore, by applying the rule and thus lowering the standard of care, the courts may be allowing inferior health care to be considered adequate. Few physicians would be prepared to recognize geographic location as more important than education and training when measuring competence.

150. [1975] 6 W.W.R. 639 (Alta. C.A.).

151. Waltz, supra n. 129 at 420.

152. Cook v. Lichtblau (1962) 144 So. 2d 312 at 316 (Fla. App.).

The rule was created by the judiciary for the limited purpose of protecting some doctors at a certain time in our history, but times have changed. Now with national standards of competence set by professional examinations and the development of continuing medical education there seems less need to lower the standard on the basis of locality alone. If the doctor can show that because of his geographic location adequate facilities or equipment or staff were not available, then the standard of care he must meet ought to be altered accordingly but it ought not to be automatically lowered. A reasonable approach was set out by an American court:¹⁵³

The proper standard is whether the physician, if a general practitioner, has exercised the degree and care and skill of the average qualified practitioners, taking into account the advances in the profession. In applying this standard it is permissible to consider the medical resources available to the physician as one circumstance in determining the skill and care required. Under this standard some allowance is thus made for the type of community in which the physician carries out his practice....One holding himself out as a specialist should be held to the standard of skill of the average member of the profession practising the speciality, taking into account the advances in the profession. And, as in the case of the general practitioner, it is permissible to consider the medical resources available to him.

The effects of some of the factors in the circumstances surrounding the treatment have been explored. Such matters will have a bearing in each case on the standard of care expected of the practitioner. The doctor is expected only to act reasonably in the practice of his profes-

153. Brune v. Belinkoff *supra* n. 138 at 798. Note that the rule seems to be a North American phenomenon. Nathan, *supra* n. 19 at 22; Van Wyck v. Lewis *supra* n. 10 at 444.

ion, not to insure his patient's health:¹⁵⁴

The standard of care which the law requires is not insurance against accidental slips. It is such a degree of care as a normally skillful member of the profession may reasonably be expected to exercise in the actual circumstances of the case in question. It is not every slip or mistake which imports negligence.

(c) Injury

(i) An essential

The plaintiff cannot succeed in a negligence action unless he proves that he has suffered a material injury¹⁵⁵ also called a "loss" or "damage". Proof of the other essentials of the negligence action will be of no avail unless he also satisfies the court that he has suffered a loss which was caused by the defendant's actions.¹⁵⁶ The requirement of damage is so basic that cases of careless conduct without resultant harm are rarely brought to court. A patient who has received care or treatment by a doctor that seems below standard but who has suffered no loss may have a basis upon which to report the doctor to the professional association but would be ill-advised to waste time and money on a law suit unless the action could be brought as a battery for which no injury need be proven.¹⁵⁷

154. Mahon v. Osborne [1939] 2 K.B. 14 at 31 (C.A.).

155. Linden, supra n. 31 at 123.

156. Fleming, supra n. 50 at 104.

157. Although his damages might still be nominal: see supra Chapter 3.

In a Manitoba case¹⁵⁸ the plaintiff who had been wounded in the leg by a bullet consented to recommended surgery to remove fragments of shell. The surgeon could not locate any foreign bodies and the plaintiff continued to suffer and sued, alleging that the seven to eight inch incision had caused injury. However, the evidence was that the course of the bullet had been followed and, in any case, the wound healed and the incision caused no injury. The court held that the plaintiff had not established any damage or loss and that any disability was entirely due to the gunshot wound. The result might have been different had the doctor not followed the bullet wound or had infection from the incision resulted.

A strange case¹⁵⁹ involved a plaintiff injured in an accident at his place of employment and attended to by the defendant doctor, who requested that he return for follow-up examinations, which the patient did until he was hospitalized in another city for a different problem. The next time he saw the doctor he was seeking a paper for the purposes of Workmens' Compensation. However, the doctor refused to give him any papers for the Board because he had missed the last visit, and the plaintiff sued for negligence in the original treatment and for the refusal to provide the papers needed. The Court of Appeal dismissed the case, saying that there was no negligence in the treatment and no damage was suffered by the plaintiff from the refusal of the doctor to comply with the patient's request for documentation, as the Board was able to

158. Browne v. Lerner (1940) 48 Man. R. 126 (K.B.).

159. Pollerin v. Stevenson *supra* n. 22.

get the required information from other sources. Seeking the assistance of the professional association might have been the patient's appropriate remedy in this situation.

An intern under the supervision of a surgeon negligently removed part of a child's uvula in the course of a tonsillectomy. The expert evidence was that the child would suffer no disability as a consequence and the action was dismissed.¹⁶⁰

In an English case, a dentist failed to diagnose a jaw fracture which occurred as he was extracting a tooth. The expert evidence indicated that the dentist had met the standard of care and that such fractures could occur without negligence. As to the allegation that it was negligence not to diagnose the fracture, the judge said that there was no proof that any damage resulted from the failure to diagnose because even if it had been, no treatment would have been given.¹⁶¹

While it is fatal to a plaintiff's claim in negligence to be unable to prove injury, proof of injury alone is not enough either. In an action against a chiropractor¹⁶² the court acknowledged that the plaintiff had "suffered cruelly" from the defendant's manipulations, yet said:¹⁶³

160. McNamara v. Smith [1934] 2 D.L.R. 417 (Ont. C.A.).

161. Fish v. Kapur [1948] 2 All E.R. 176 (K.B.).

162. Rutledge v. Fisher [1940] 3 W.W.R. 494 (B.C.Co. Ct.); see also Armstrong v. Bruce *supra* n. 11.

163. Rutledge v. Fisher *id.* at 499.

The plaintiff, however, knew that the defendant merely assumed to treat human ailments in accordance with the system taught in the school of chiropractic and the burden is on him to show by competent evidence, not merely that the treatment given by the defendant was injurious, or ineffective, but that requisite care and skill was not exercised by the defendant in administering it. This he has not done and the action must be dismissed.

The plaintiff had failed to prove that the chiropractor had breached the standard of care.

Therefore negligence cannot be assumed only because an injury has been suffered, but without proof of injury there can never be liability for negligence.

(ii) Compensation for injury

Assuming that the requirements for a finding of negligence have been proven,¹⁶⁴ the judge, or jury if there is one, has the task of assessing the quantum of damages, that is, attaching a dollar value to the plaintiff's claim. The fundamental purpose of negligence law is the compensation of the victim, and the aim is to restore the plaintiff as nearly as possible to his position prior to the negligent act. As explained by a leading Canadian writer:¹⁶⁵

164. See supra.

165. Charles, Justice in Personal Injury Awards: The Continuing Search for Guidelines in Studies in Canadian Tort Law 37 at 39 (2d ed. Klar 1977); this chapter is an excellent discussion of the principles and practices in damage assessment. Charles, A New Handbook on the Assessment of Damages in Personal Injury Cases from the Supreme Court (1978) 3 C.C.L.T. 344; see also Hawley, Assessment of Damages for Permanent Incapacitating Injuries (1975) 13 Alta. L. Rev. 430.

Since perfect compensation in the sense of physical reconstruction of the victim to his pre-accident condition is generally impossible, the initial premises upon which damage awards are based is that damages should be computed so that the dollars awarded will be adequate compensation for the loss which was suffered by the injured party. To the extent that money damages can make the victim whole again, the award of compensation is considered to be the fairest solution to both plaintiff and defendant.

The principles of quantification will not be discussed in detail because they are no different from those applied in general negligence law, which are adequately dealt with elsewhere.¹⁶⁶ Three cases are worth noting, however, because of the nature of the injuries involved.

In a case of a six day old baby who was left with a deformed penis after circumcision,¹⁶⁷ the assessment of general damages was extremely difficult because of the age of the child and the unknown emotional effect of the injury on the child, but they were set at \$10,000.

In another case,¹⁶⁸ a polio victim underwent an operation to improve the use of his right leg by the fusion of certain bones. In error, the operation was performed on the left leg. The trial judge found that the permanent deprivation of movement in the formerly good leg was "not as great as might at first be supposed by a layman,"¹⁶⁹ noted that the plaintiff was "the sort of young fellow who will shrug off his physical disabilities"¹⁷⁰ and awarded \$8,000 general damages.

166. Goldsmith, Damages for Personal Injury and Death in Canada (1974).

167. Gray v. La Fleche [1950] 1 D.L.R. 337 (Man. K.B.).

168. Staple v. Winnipeg (1956) 18 W.W.R. 625 (Man. Q.B.).

169. Id. at 631.

170. Id. at 632.

In a very recent case,¹⁷¹ a healthy and active woman entered hospital as an outpatient for a microlaryngoscopy. As a result of the anaesthetist's negligence in performing transtracheal ventilation, she was rendered a quadriplegic, and damages were awarded against three doctors in a total sum in excess of \$700,000. This award is consistent with those set for plaintiffs with similar injuries from motor vehicle and sports accidents.¹⁷²

(d) Causation

A plaintiff who proves duty, breach of the standard of care and injury will still be unsuccessful in bringing his action unless he proves the causal link between the breach of the standard of care and his injury. The causal link is tested in two ways: the defendant's conduct must be both the actual cause, or cause-in-fact and the legal cause, or proximate cause of the injury.

(i) Cause-in-fact

This is a determination of the factual, or technical, scientific cause of the plaintiff's injury. The complexity of the human body and the uncertainties which still surround its nature, together with the

171. Holmes v. Bd. of Hospital Trustees of London supra n. 16.

172. See Andrews v. Grand & Toy (1978) 3 C.C.L.T. 225 (S.C.C.); Arnold v. Teno (1978) 3 C.C.L.T. 272 (S.C.C.); Thornton v. Prince George Bd. of S. Trustees (1978) 3 C.C.L.T. 257 (S.C.C.). For an analysis see Charles, Justice in Personal Injury Awards supra n. 166.

advanced state of medical technology exacerbate the overwhelming task that the plaintiff has in proving that the defendant's conduct was the factual cause of his injury. A rule of evidence referred to as res ipsa loquitur to be discussed in a later chapter¹⁷³ is sometimes of great help to plaintiffs, but it is not always available. Even defendants, who it is assumed have the most knowledge and the best evidence, sometimes have difficulty in proving how or when damage occurred.¹⁷⁴ The subject of the quest is further obscured by the conviction of many plaintiffs that any change in bodily condition following medical treatment has been "caused" by that treatment.¹⁷⁵

A legal test for cause-in-fact often used in general negligence law is sometimes helpful and has seen some use in medical negligence cases. Although it is not always identified¹⁷⁶ as such, it is in the sine qua non, or "but for" test¹⁷⁷ and involves an inquiry as to whether the injury would not have occurred "but for" the defendant's conduct.

A case illustrative of the difficulties involved is one in which the plaintiff was suspected of having sarcoidosis involving the larynx,¹⁷⁸

173. See infra Chapter 7.

174. See Radclyffe v. Rennie [1965] S.C.R. 703 where each defendant was trying to prove who left the gauze in the plaintiff.

175. See Girard v. Royal Columbian Hospital (1976) 66 D.L.R. (3d) 676 at 680 (B.C.S.C.).

176. Penner v. Theobald supra n. 75 at 231; Smith v. Auckland Hospital Bd. [1965] N.Z.L.R. 191 at 199 (N.Z.C.A.).

177. Linden, supra n. 31 at 127.

178. Finlay v. Auld [1975] 1 S.C.R. 338; see also Tiesmaki v. Wilson [1975] 6 W.W.R. 639 (Alta. C.A.).

and underwent a scaline node biopsy. The biopsy proved negative, but following the biopsy the plaintiff suffered laryngeal complications. Her husky voice and difficulty in swallowing was found to be due to a paralyzed vocal cord occasioned by injury to a nerve. Many explanations were advanced as to the cause-in-fact of the injury including a tumor, tuberculosis, sarcoidosis or the biopsy. The most likely cause seemed to be the sarcoidosis, and in any event the doctor was exonerated by the court because the nerve involved could not have been reached during the biopsy.

The difficulty for a judge in settling on the cause-in-fact is evident, and because of the uncertainty in some cases, judges do not always agree. In a case where the interns who interpreted x-rays and failed to diagnose a dislocated fracture of the neck, the majority of the Supreme Court of Canada ruled that but for this negligence the plaintiff would have died.¹⁷⁹ However, a dissenting Justice¹⁸⁰ felt that there was no evidence which showed that the ileus (a paralysis of a portion of the small intestine), which caused the death, was the result of the failure to diagnose the fracture; there was evidence that paralytic ileus could result from a number of causes.

Occasionally it happens that a court, despite much effort, is unable to determine the cause-in-fact. In one case, a court sat for 27 days and heard a great deal of technical medical evidence but was unable to determine the cause of death, and therefore dismissed the case, because

179. Fraser v. Vancouver General Hospital *supra* n. 70.

180. Id. at 70 *per* Locke J.

the plaintiff was unable to prove it.¹⁸¹

Strong and consistent expert evidence is of crucial importance to a court engaged in this inquiry. Where such evidence is available, the court's task is much eased. For example, in a recent case, a patient had an operation for a diseased artery under spinal anaesthetic administered by the defendant.¹⁸² Following the surgery the patient suffered permanent partial paralysis of both legs and brought action. However, tests performed after the operation convinced all the expert witnesses that the spinal cord damage was not caused by the anaesthetist's work but rather was more likely a consequence of the pre-existing condition of the plaintiff's arteries.

Nevertheless the determination of the cause-in-fact is as essential as it is difficult, because it is preliminary to the determination of whether the defendant's conduct was also the proximate cause of the injury alleged; without proof of cause-in-fact, the plaintiff will lose his case.

(ii) Proximate cause

Determining cause-in-fact is a more or less scientific inquiry into the cause-effect relationship which brought about the injury. Proximate

181. Wilson v. Stark *supra* n. 43; see also Cavan v. Wilcox (1974) 2 N.R. 618 (S.C.C.), an action against a nurse.

182. Girard v. Royal Columbian Hospital *supra* n. 175; see also Hutchinson v. Robert [1933] O.W.N. 314 (Ont. C.A.) where the defendant's experts testified that the defendant was prudent in leaving a fragment of an instrument in the wound. In any case, the injury complained of, sinus trouble, was not caused by the doctor.

cause, on the other hand, is an entirely different inquiry which really relates in no way to "true" cause at all, although the courts often use the language of causation. Rather, the notion of proximate cause, or "remoteness" is a liability limiting device invented by the courts. It is an accepted tenet of general negligence law that a defendant ought not necessarily to be liable for all damage that his conduct causes, but only that which was "foreseeable" to a reasonable person in the defendant's position.¹⁸³ Any damage occurring which falls outside of that which is reasonably foreseeable is said to be "too remote" and the defendant will not be held liable for it. For example, assume that the cause-in-fact of a patient's death is complications arising from paralysis of the small intestine arising out of an undiagnosed neck fracture.¹⁸⁴ While scientifically the cause of the patient's death may be the failure to diagnose and then treat the neck fracture, this may not be the proximate cause. It could be held that it was not foreseeable that a failure to diagnose a neck fracture would result in the death of the patient by paralytic ileus; in other words, this ailment is too remote from the failure to diagnose to justly hold the doctor liable.¹⁸⁵

183. Overseas Tankship (U.K.) v. Morts Dock & Engineering Co. (The Wagon Mound) [1961] A.C. 388 (P.C.). For a thorough discussion of the various tests used to delineate proximate cause see Linden, *supra* n. 31 at 305-355; see also Child v. Vancouver Gen. Hospital [1970] S.C.R. 477.

184. The facts are those of Vancouver Gen. Hospital v. Fraser *supra* n. 70.

185. See dissent of Locke J. *id.* at 57; see also Elverson v. Doctors Hospital (1974) 4 O.R. (2d) 748 (Ont. C.A.) where it was held that injury suffered by the patient's husband who assisted a nurse in lifting a bed was not reasonably foreseeable.

It is clear that the Supreme Court of Canada regards the reasonable foreseeability test as the appropriate one for determining proximate cause in medical negligence cases. In the words of the court in Cardin v. Montreal:¹⁸⁶

Certainly, doctors should not be held responsible for unforeseeable accidents which may occur in the normal course of the exercise of their profession. Cases necessarily occur in which, in spite of exercising the greatest caution, accidents supervene and for which nobody can be held responsible. The doctor is not a guarantor of the operation which he performs or the attention he gives. If he displays normal knowledge, if he gives the medical care which a competent doctor would give under identical conditions, if he prepares his patient before operation according to the rules of the art, it is difficult to sue him for damages, if by chance an accident occurs. Perfection is a standard required by law no more for a doctor than for other professional men, lawyers, engineers, architects, etc. Accidents, imponderables, what is foreseeable and what is not, must necessarily be taken into account. [emphasis supplied]

And from University Hospital Board v. Lepine:¹⁸⁷

The question of whether there was or was not negligence in a given situation has been dealt with in many judgments and by writers at great length. One principle emerges upon which there is universal agreement, namely that whether or not an act or omission is negligent must be judged not by its consequences alone but also by considering whether a reasonable person should have anticipated that what happened might be a natural result of that act or omission. As was said by Lord Thankerton in Glasgow Corporation v. Muir [[1943] A.C. 448 at 454-5],

"The court must be careful to place itself in the position of the person charged with the duty and to consider what he or she should have reasonably anticipated as a natural and probable consequence of neglect, and not to give undue weight to the fact that a distressing accident has happened...". [emphasis supplied]

186. Supra n. 29 at 494.

187. Supra n. 79 at 579-580.

Apart from setting out the general principle, these extracts also constitute a directive from the highest court in Canada that the remoteness principle must be applied with reason and justice.

A review of the decisions shows that while medical negligence law is usually consistent with general negligence law where the finding of proximate cause is concerned, it is not always so.

A. Pre-treatment conditions

Medical care is frequently administered to a person who has (i) a peculiar weakness or susceptibility, (ii) a pre-existing disease, or (iii) a traumatic condition brought about by injury.¹⁸⁸ Each situation will be discussed in turn.

Thin-skull rule. In general negligence law, to some extent at least, the defendant takes his victim as he finds him. This has been described as the thin-skull rule,¹⁸⁹ and stated as follows:¹⁹⁰

One who is guilty of negligence to another must put up with idiosyncracies of his victim that increase the likelihood or extent of damage to him...it is no answer to a claim for a fractured skull that its owner had an unusually fragile one.

188. See Rozovsky, supra n. 19 at 47.

189. Dulieu v. White & Sons [1901] 2 K.B. 669 (C.A.). For an excellent discussion of the thin-skull problem and the case law see Linden, supra n. 31 at 322-330.

190. Owens v. Liverpool Corpn. [1939] 1 K.B. 394 at 400 (C.A.).

The thin-skull victim might not recover damages under a strict application of the foreseeability test because peculiar weakness or susceptibility is often not foreseeable, but there is authority that he is not precluded from recovery either.¹⁹¹ There are policy reasons for the creation and nurturing of this exception to the foreseeability test, which include the difficulty of determining with certainty what is foreseeable, the protection of vulnerable persons, the deterrence of sub-standard conduct, and the wider distribution of loss due to tortious activity.

The critical questions when determining the causation issue are 1) was the doctor's conduct a cause-in-fact of the injury and, if so, was it a proximate cause? 2) If the answer to the first part of the question is yes and to the second part is no, then might the patient still recover as a thin-skull person?

Although many of the fact situations in medical negligence cases would seem to have been appropriate for the application of the thin-skull rule, there is no case to be found in which it has been expressly applied.¹⁹² The cases that might have seen reference to it have included cases where the patients have had a pre-existing circulatory or

191. Smith v. Leech Brain & Co. [1962] 2 Q.B. 405 (Q.B.D.).

192. But see Craig v. Soeurs de Charité de la Providence [1940] 2 W.W.R. 80; affirmed [1940] 3 W.W.R. 336 (Sask. C.A.) where the patient's damages for a hot water bottle burn were not lessened because as a diabetic he suffered more. In modern times, it could be implied that the defendant hospital took him as he was.

blood problem¹⁹³ and a potential for a toxic or allergic reaction to drugs.¹⁹⁴ The doctor's actions have included giving an anaesthetic¹⁹⁵ or injection,¹⁹⁶ and failing to diagnose¹⁹⁷ or prescribe drug therapy.¹⁹⁸ In all cases the patients suffered injury, but in none of them did they recover. In all of the cases the courts seemed to rule that the doctors' actions were not the cause-in-fact, and with that decision the case for the plaintiff is over.

The result may be just in view of the fact that unlike the motor vehicle operator, who will rarely injure a thin-skull person, the doctor treats many patients who are peculiarly vulnerable, and hence his potential exposure to liability is much greater. On the other hand, the doctors' training and constant experience with such persons place him in a position where he is more able to foresee their peculiar condition. However, the practice of medicine is high in social utility, and the courts are inclined not to increase the potential liability (by, for example, applying the thin-skull rule) of persons engaged in such enter-

193. Girard v. Royal Columbian Hospital *supra* n. 175; Parsons v. Schmok *supra* n. 111; Serre v. de Tilly (1975) 58 D.L.R. (3d) 362 (Ont. H.C.); Thompson v. Toorenburg (1973) 50 D.L.R. (3d) 717 (B.C.) affirmed without written reasons [1973] S.C.R. at vii; Van Hartman v. Kirk [1961] V.R. 544 (Vic. S.C.).

194. Robinson v. Post Office [1974] 2 All E.R. 737 (C.A.); Winteringham v. Rae (1963) 55 D.L.R. (2d) 108 (Ont. H.C.).

195. Girard v. Royal Columbian Hospital *supra* n. 175.

196. Robinson v. Post Office *supra* n. 194; Winteringham v. Rae *supra* n. 194.

197. Serre v. de Tilly *supra* n. 193.

198. Parsons v. Schmok *supra* n. 111.

prises.¹⁹⁹

Two cases are worth noting because in each case it appears that the doctor's conduct could have been characterized as below the standard of care as the patient was certainly a thin-skull person.

In an English case²⁰⁰ the doctor administered an injection of anti-tetanus serum to a patient who had had such treatment before. The experts agreed that encephalitis was one of the risks, albeit rare, of administering the serum to such a patient. While the doctor was aware that the patient had been similarly treated in the past, he did not follow the proper test dose procedure, and the patient contracted encephalitis. Clearly, "but for" the administration of the serum with a test dose, the patient would not have suffered the brain damage that he did, but the court held that the doctor's negligence was not the cause of the injury. The patient required the treatment because of a wound suffered at work, and the defendant employer was held liable both for the wound and the brain damage. Had the issue of the doctor's negligence for administering the serum at all been resolved in favour of the patient, the doctor would have been liable for the extreme injuries suffered by this thin-skull patient.

199. Linden, supra n. 31 at 82 et seq.

200. Robinson v. Post Office supra n. 194.

A Canadian case, no less complicated,²⁰¹ involved a patient with a history of arterial disease who was operated on for a "left femoral popliteal vein by-pass graft" under a spinal anaesthetic administered by the defendant. The expert evidence indicated that the introduction by the defendant of an analgesic could send an artery into spasm, as the patient suffered from a pre-existing plaque (fatty tissue) problem, the result would be a reduced blood supply, causing partial paralysis, which was what happened. It appears that the action of the doctor was the cause-in-fact and even if the injury was not foreseeable, given that the patient was a thin-skull person, he could have recovered under general negligence principles. However, the thin-skull rule does not apply unless a breach of the standard of care is found, and none was found in the procedure although there was evidence that the surgeon had booked a general anaesthetic and the patient had prohibited a spinal, yet a spinal was given.

It is arguable that a type of thin-skull case occurs when an injured plaintiff commits suicide and one authority has argued that a negligent defendant should be required to compensate for it.²⁰² However, in medical negligence cases the reasonable foreseeability test has been applied in such cases without any reference to the thin-skull rule.²⁰³

201. Girard v. Royal Columbian Hospital *supra* n. 175; see also Thompson v. Toorenburg *supra* n. 193 where a patient previously diagnosed as having a mitral stenosis was treated with "harmful procedures" after an accident but these were not found to have caused her death. See infra.

202. Linden, *supra* n. 31 at 353.

203. Recovery was barred in University Hospital Bd. v. Lepine *supra* n. 79; Stadel v. Albertson [1954] 2 D.L.R. 328 (Sask. C.A.) but allowed in Villemure v. Turcot [1973] S.C.R. 716.

The dearth of judicial comment on the thin-skull rule in the medical negligence case may be due to any one or a combination of the following factors: the cases that have arisen did not fulfill the requirements, policy reasons precluded its application to doctors and hospitals, or the determination of cause-in-fact and proximate cause from complex medical evidence in some cases is nearly impossible.

Disease. Many patients who seek medical care have a disease evidenced by symptoms.²⁰⁴ If the condition worsens with the administration of medical care or the lack of it, the patient may sue and the court must decide whether the doctor's conduct was the cause-in-fact of the injury and, if so, it was the proximate cause. Liability will not be imposed for a breach of the standard of care and the resultant injury unless the answer to both inquiries is affirmative. Unfortunately it is usually impossible to ascertain from the judgments in which no liability is found, which question was answered in the negative.

In an early case it was decided the "septicemia had set in without any fault of the defendant"²⁰⁵ who had attended her in childbirth.

In another early case²⁰⁶ a doctor who misdiagnosed a kidney condition was said not to have met the requisite standard of care. But while

204. Compare with the thin-skull cases, supra, where there may be no symptoms.

205. McQuay v. Eastwood (1886) 12 O.R. 402 (C.A.). A modern fact situation is seen in Mudrie v. McDonald (1975) unreported (B.C.S.C.) Hutcheon J. where the patient alleged negligence in the removal of an I.U.D. in that she suffered afterwards from an inflammatory disease of the pelvis. The court held that there was no negligence and questioned whether the disease was present at the time of the removal.

206. Turriff v. King supra n. 135 at 676.

he was held liable for damages for the extra treatment and pain undergone by the plaintiff he was held not responsible for the damage to her kidney which took place prior to his being called in on the case.

An early case²⁰⁷ from Ontario involved a child who was suffering from diphtheria but through a conflict of a doctor and a medical health officer received no medical care for several days. When the health officer eventually visited her she seemed to be recuperating but died shortly thereafter of "paralysis of the heart". The court held that negligence of the officer was not proved to be the cause of the injury.

The foreseeability test as we know it had not been enunciated at the time of these early cases, but it would seem that the damage in each was thought to be too remote from the doctor's actions to justify liability.

The issue arose in two recent cases. In Finlay v. Auld²⁰⁸ the Supreme Court of Canada held that a pre-existing disease, sarcoidosis, was the sole cause-in-fact of the plaintiff's injuries.

The other case is a little different in that the action was based in part on the failure to treat.²⁰⁹ The patient related to the doctor by telephone what seemed like innocuous symptoms, but it later developed that the condition was serious. The court held that there was no causal link established between the failure to treat the injury suffered because a reasonable man in the doctor's position would not have foreseen the consequences.

207. Simpson v. Local Bd. of Health of Belleville (1917) 40 O.L.R. 406 (C.A.).

208. Supra n. 178.

209. Cavan v. Wilcox (1973) 44 D.L.R. (3d) 42 (N.B.C.A.); reversed (no appeal on this point) (1974) 2 N.R. 618 (S.C.C.); Dale v. Munthali supra n. 54.

Trauma. Many of those who seek medical care have suffered trauma from an accident or some other cause. If the doctor is sued after rendering treatment, the court must determine whether the doctor's action was a contributing cause-in-fact of the injury complained of and, if so, whether his action was also a proximate cause. As stated previously,²¹⁰ there will be no liability unless both criteria are satisfied,²¹¹ and again, the courts rarely state the basis of a holding that there has been no causal link.

In an early Nova Scotia case²¹² a patient who had been run over by a coke trolley alleged that the doctor had severed a nerve in his leg. The trial judge held that the nerve was severed in the accident, and thus the doctor's actions were not the cause-in-fact of the nerve damage.

The victim of what became a murder attended at the emergency department of an English hospital complaining of vomiting and malaise.²¹³ Receiving no treatment, he returned to his place of work and died of arsenic poisoning within six hours. In his widow's action against the doctor and the hospital, it was held that the failure to admit and treat the plaintiff was a breach of the standard of care but that this negligence was not the cause of death because the required treatment could

210. Cardin v. Montreal supra n. 29 and University Hospital Bd. v. Lepine supra n. 79 at 579-580.

211. See generally Linden, supra n. 183.

212. Zirkler v. Robertson supra n. 133. A new trial was directed since the trial judge found liability on an issue not put forward by the pleadings, namely, the failure to suture the nerve.

213. Barnett v. Chelsea and Kensington Hospital [1968] 2 W.L.R. 422 (Q.B.).

not have been administered in time even if the deceased had been admitted. Again, the negligence was not the cause-in-fact of the injury.

Another case involving failure to diagnose and improper treatment²¹⁴ concerned a patient who had previously been diagnosed as having "a moderately severe mitral stenosis, a narrowing of the opening of the valve which allows blood to come back from the lung to the left side of the heart". She was treated in an emergency department for apparently minor injuries sustained in a motor vehicle accident and released. In fact, the collision precipitated acute pulmonary edema, and she was readmitted two hours later. For two hours until her death she was given incorrect and actually harmful treatment, but the court concluded:²¹⁵

The harmful procedures may have hastened the patient's death, but, if they did (upon which I express no opinion), they did not cause it. Death was the result of acute pulmonary edema and the edema was brought on by the collision. Mrs. Thompson would almost certainly have recovered if proper treatment had been applied speedily; the doctors failed to apply the treatment and so failed to save her life, but they did not cause her death.

At first this may appear to be a finding of no cause-in-fact, but it seems clear that the negligence was the cause-in-fact, and therefore the case is better regarded as a no proximate cause decision.

214. Thompson v. Toorenburgh *supra* n. 193.

215. Id. at 721.

The failure of a doctor to warn a patient of risks has been relied upon in some cases as a cause of injury.²¹⁶ The failure to warn of haemorrhaging, the dangerous side-effect of a drug, brought liability to a doctor in Ontario²¹⁷ when the risk materialized and caused the plaintiff injury. However, in another case, the failure to warn of the risk of haemorrhage following a dental extraction was held not to have caused the patient's loss.²¹⁸ Instead it was held that the patient's failure to take action was the sole basis of his injury, although the trial judge acknowledged that in some cases failure to warn might be negligence. Thus, the reasonable foreseeability test of proximate cause is flexible enough to exclude compensation for the patient who bleeds excessively for over twenty-four hours and takes no action and to allow compensation for the patient who is given a dangerous drug without any information.

B. Combined Cause

Injuries from an accident and from a doctor's negligence may combine to cause the patient's ultimate loss. When this happens, the courts

216. See Smith v. Auckland Hospital Bd. *supra* n. 176 at 198 which puts the issue of causation in cases where the patient alleges he would not have consented to treatment had he known of a certain risk; Hutchinson v. Robert *supra* n. 182, where failure of a doctor to alert a patient to the fact that he had left a bit of an instrument in her was said not to have caused her loss; see also supra Chapter. 4.

217. Crichton v. Hastings *supra* n. 14.

218. Murrin v. Janes [1949] 4 D.L.R. 403 (Nfld. S.C.).

attempt to delineate the consequences of the two causes and hold the doctor liable only for the loss caused by his negligence. This is so whether the negligent treatment precedes or follows the accident, so a surgeon was held liable only for severing a nerve and not for the reflex sympathetic syndrome resulting from the plaintiff's accidents,²¹⁹ and a general practitioner was held liable only for the difference between moderate and minimal muscle loss of a leg where it was found that the accident would have caused the plaintiff the lesser injury.²²⁰ Placing a dollar value on the doctor's portion of such losses is very difficult.

The court's attempts to attribute cause to the proper source are well illustrated by the cases in which the patient has complained of disease or trauma following non-negligent medical care. Injury which followed proper treatment of a dislocation was attributed to the patient rather than the doctor,²²¹ as was the occurrence of a pelvic disease following the non-negligent removal of an intrauterine contraceptive device.²²² Similarly a second disc extrusion was held to be the cause of the patient's need for a second operation, rather than the first operation.²²³

219. McKeachie v. Alvarez *supra* n. 50.

220. Park v. Stevenson Memorial Hospital (1974) unreported (Ont. H.C.) Holland J.

221. Stamper v. Rhindress (1906) 41 N.S.R. 45 (C.A.).

222. Mudrie v. McDonald *supra* n. 205.

223. Lepp v. Hopp *supra* n. 52.

Two possibilities exist when the patient is the victim of a tortfeasor, for example, a negligent motor vehicle operator. If the medical treatment administered is not negligent, but does cause further injury, the original tortfeasor is liable for the entire loss, since medical treatment is a foreseeable consequence of injuring another.²²⁴ However, if the medical treatment is negligent, the plaintiff must sue both the original tortfeasor and the doctor.²²⁵

This situation is referred to as one of novus actus interveniens; that is, it is said that the chain of causation between the original tortfeasor's conduct and the plaintiff's injury has been broken by the intervening act of a third party, in this case the doctor. In the United States, the original tortfeasor is held liable for the total loss in such situations,²²⁶ and the plaintiff is not placed in the undesirable position of having to sue more than once. A similar move in Canadian law would find support in the remarks of an Ontario trial court²²⁷ where it was said that an original tortfeasor may be respon-

224. Mercer v. Gray [1941] O.R. 127 (C.A.); Winteringham v. Rae *supra* n. 194; Watson v. Grant (1970) 72 W.W.R. 665 (B.C.S.C.); Thompson v. Toorenburg (1972) 29 D.L.R. (3d) 608; affirmed 50 D.L.R. (3d) 717 (B.C.C.A.); Robinson v. Post Office *supra* n. 194; Robinson v. Englot [1949] 2 W.W.R. 1137 (Man. Q.B.).

225. If the victim sues only the original tortfeasor he may third party the doctor: see David v. T.T.C. (1976) 77 D.L.R. (3d) 717 (Ont. H.C.). For a case involving a doctor as the first tortfeasor see Price v. Milawski *supra* n. 117.

226. Thompson v. Fox (1937) 192 A. 107 (Pa. S.C.).

227. Kolesar v. Jeffries (1974) 9 O.R. (2d) 41; varied 12 O.R. (2d) 142; affirmed on other grounds (sub nom. Joseph Brant Memorial Hospital v. Koziol) 2 C.C.L.T. 170 (S.C.C.) with no ruling on this point. See also Fleming, *supra* n. 50 at 204.

sible for the subsequent negligence of a doctor or hospital unless it is "outside the range of normal experience". This seems to imply that some negligent medical treatment is foreseeable, and some is not, and since such a determination would be extremely difficult, if not impossible, the present Canadian approach where each tortfeasor bears the burden of the loss he has caused seems preferable.²²⁸

3. Duties and Attendant Standards of Care

The most common components of the doctor's duty of care to his patient are the duty to attend, diagnose, refer, treat and instruct. It is impossible to state in the abstract what course of action will be negligent and therefore the scope of the standard of care involved in the discharge of each of these duties will be analyzed with reference to the case law.

(a) The Duty to Attend

As has been discussed,²²⁹ while a doctor is under no legal duty to treat a patient, once he undertakes to do so, certain legal consequences follow. Assuming that the doctor-patient relationship has been formed, what is the scope of the duty to attend a patient?

228. For a contrary opinion see Linden, supra n. 31 at 352.

229. See supra Chapter 2 and s. 2.(a) of this Chapter.

The doctor will be held to have failed to meet his duty to attend only if it leads to injury or damage to the patient. He may be infamous among his colleagues for his lack of diligence in attending on his patients in hospital, or among his patients for his failure to keep office appointments or return calls yet there will be no liability if this unprofessional and sub-standard conduct falls short of causing foreseeable injury to the patient.

If it appears that a patient has been injured, reference will be had to the relevant standard of care in the circumstances. The court will consider the urgency of the request, the nature of the condition described, the alternatives available and the other commitments the doctor may have. Each case will depend upon its own circumstances.²³⁰

A patient being treated by his doctor for pneumonia was given an injection in the arm which became bruised, swollen, cold to the touch and very painful. Early the following morning the patient's wife telephoned²³¹ the doctor, who suggested warm compresses and said that he would see the patient the next day. Gangrene set in and the patient required amputation of his fingers and thumb, and sued both the doctor and nurse who administered the shot. It was found that the bicillin injected had "found its way into the circumflex artery", but the nurse was not held negligent. The Court of Appeal²³² also said that the

230. Smith v. Rae (1919) 46 O.L.R. 518 (C.A.); Nathan, supra n. 19 at 42.

231. A common method of requesting attendance: Meredith, supra n. 9 at 70.

232. Cavan v. Wilcox supra n. 209; affirmed regarding the nurse; regarding the doctor, no appeal from the dismissal in the Appellate Division.

doctor was not negligent in failing to attend on his patient following the receipt of the information that the arm was bruised and painful, because from the condition described there appeared no urgency and an examination had been set for a reasonable time after the call.

A recent decision²³³ has raised the possibility that such a call would require the doctor at least to make inquiries where the information given was scanty. Since the doctor is in the best position to know what symptoms would be a cause for concern it seems appropriate to expect him to ask questions where the information received is scanty or vague. If he is in any doubt, the cautious and it would seem fairly standard practice is to have the patient attend at a hospital emergency department forthwith or at his office if appropriate.

A child who was ill with fever and stomach pains was taken to the same hospital emergency department on two consecutive days and examined but not admitted on both occasions. She was finally admitted at another hospital and an operation performed but became a quadriplegic.²³⁴ The case was heard on an application to extend the limitation period, which was denied, and so the matter never came to trial. Had it done so, one issue would have been the duty of the first doctor to attend by admitting the child.

In an English case²³⁵ the doctor on duty in emergency was found to have been negligent by failing to examine or admit a patient with

233. Dale v. Munthali *supra* n. 54.

234. Mumford v. Children's Hospital of Winnipeg [1977] 1 W.W.R. 666 (Man. C.A.).

235. Barnett v. Chelsea and Kensington Hospital *supra* n. 213.

symptoms of what turned out to be arsenic poisoning, but because no causal link between the negligence and the patient's death was made out there was no liability found.

When a patient presents himself or is brought to emergency the request for care should be presumed to be urgent in spite of the fact that emergency departments are sometimes misused by some patients. To be remembered here is that it takes little for the doctor-patient relationship, the basis of legal duty, to be created.²³⁶

An early Saskatchewan case²³⁷ illustrates that if alternate medical care is available a doctor is justified in assuming that a patient who says that he will pursue it, will do so. A doctor was returning from a professional visit to a remote area when the patient's husband called him because the patient was in early labour. Shortly after his arrival she was delivered of a three to four months' fetus. The doctor did the best he could with the equipment he had but a portion of the placenta remained in the uterus. The court accepted his testimony that the patient said she would come into the hospital for further treatment and held that he was entitled to rely on her commitment to attend to her own health by consulting her family doctor. In fact, he had out of interest inquired of her family doctor and at the hospital regarding her condition, and she was not successful in her suit against the doctor for negligent treatment.

236. See supra Chapter 2. For a discussion of the creation of a relationship arising from a statute see Simpson v. Local Bd. of Health of Belleville supra n. 207.

237. Hampton v. Macadam supra n. 103.

A doctor's other responsibilities are relevant to the question of when he must attend on his patient.²³⁸ A doctor who was notified by a husband of an expectant mother about 7:30 p.m. that the patient was in labour, advised him that because of other patients he could not attend before 8:30 p.m. The husband acquiesced, saying that the attending nurse believed that the child would arrive at about 11:00 or 12:00 p.m. As it happened the child was born dead by 8:20 p.m. Holding that the doctor was not negligent, the court said:²³⁹

I do not think that the plaintiff is right in the contention that when a doctor undertakes to attend a case of this description he thereby undertakes to drop all other matters in hand to attend the patient instantaneously upon receiving a notification. The doctor must, having regard to all circumstances, act reasonably. Here the first message received did not indicate any urgency. It was a request for him to call some time during the evening, and the message received from the husband did not then indicate any extreme urgency. The doctor had other patients who had some claim upon his time and attention. Had he been given to understand that the plaintiff's situation was critical, undoubtedly he should, and I think he would, have dropped everything and gone to her assistance; but in view of the information that he had, I do not think it would possibly be said that he acted negligently or unreasonably. [emphasis supplied]

An extreme case of failure to attend a patient in hospital is Vail v. MacDonald²⁴⁰ where, after a closed reduction of a fracture, a general surgeon showed no concern regarding the patient's condition in spite of being alerted to it by the nursing staff. He neither consulted another doctor, prescribed medication, nor took any other steps to remedy the

238 Smith v. Rae *supra* n. 230; Nathan, *supra* n. 19 at 42.

239. Smith v. Rae *id.* at 522.

240. Supra n. 45.

apparent circulatory problem until it was too late. His attendance on the patient was described by the Court of Appeal as "casual",²⁴¹ and by the Supreme Court of Canada as "neglect".²⁴² Hospital record keeping practices and monitoring committees have an important role in setting standards in regard to the doctor's attendance upon and care of hospitalized patients.

These cases have shown that no rigid principles can be set down about the duty to attend. Some important facts have been identified and examples of conduct related but the most that can be said is that the doctor must act reasonably, having regard to all circumstances.²⁴³

(b) The Duty to Diagnose

Once the doctor has taken a person as a patient, he is under a duty to make a diagnosis²⁴⁴ and if he cannot he has a duty to refer the patient to others who can.²⁴⁵ The duty is not as onerous as it might seem; a doctor is not bound at his peril to make no mistake, although he is expected to exercise reasonable care, skill and judgment in coming to

241. (1973) 41 D.L.R. (3d) 321 at 348.

242. Supra n. 44 at 531.

243. Smith v. Rae supra n. 230.

244. Defined as "the determination of the nature of a case or disease" - Dorland's Illustrated Medical Dictionary, W.B. Saunders, Philadelphia, 25th ed. 1974.

245. See infra.

a diagnosis. If he does so he will not be held liable²⁴⁶ if mistaken. Thus a mistaken diagnosis is not necessarily a negligent one because the doctor may have met the standard of care required of him when making it. The best judicial statement of this appears in an English authority:²⁴⁷

...no human being is infallible; and in the present state of science even the most eminent specialist may be at fault in detecting the true nature of a diseased condition. A practitioner can only be held liable in this respect if his diagnosis is so palpably wrong as to prove negligence, that is to say, if his mistake is of such a nature as to imply an absence of reasonable skill and care on his part, regard being had to the ordinary level of skill in the profession.

A number of cases have commented on the care, skill and judgment to be exercised by a doctor when formulating his diagnosis. In a recent case²⁴⁸ a patient suffering from severe headache, nausea, dizziness, numbness and photophobia was diagnosed in fifteen minutes by a doctor employed in an emergency ward²⁴⁹ as having "migrainous headaches plus nervous overtone". In fact he was in the early stages of a subarachnoid haemorrhage, and some days later a recurrence caused his death. The court found liability for a misdiagnosis.²⁵⁰

246. Gibbons v. Harris supra n. 75; Penner v. Theobald supra n. 75; Dale v. Munthali supra n. 54.

247. Nathan, supra n. 19 at 57 referring to Mitchell v. Dixon [1914] A.D. 519 (S. Africa C.A.).

248. Wade v. Nayernouri (1978) 2 L.M.Q. 67 (Ont. H.C.).

249. It is worth noting that many of the actions for misdiagnosis are against doctors involved in out-patient or emergency care. See Yepremian v. Scarborough Gen. Hospital (1978) 6 C.C.L.T. 81 (Ont. H.C.).

250. Supra n. 248 at 16.

In my opinion the cases have established that an erroneous diagnosis does not alone determine the physician's liability. But if the physician, as an aid to diagnosis, does not accurately obtain the patient's history, does not avail himself in this particular case of the need for referral to a neurologist, does not perform the stiff neck tests and the lumbar puncture tests, the net result is not an error in judgment but constitutes negligence.

While it may be possible to identify some of the steps to be taken in exercising reasonable care and skill, determining whether a misdiagnosis is the result of breach of the standard or only an error of judgment is not easy. A recent case²⁵¹ stated that diagnosis is a matter of judgment. A gynecologist did a tubal ligation on a patient who afterwards suffered abdominal distension which eventually was diagnosed by a second doctor to be caused by a damaged ureter. The evidence was that although the doctor had missed the correct diagnosis he had exercised reasonable care, skill and judgment in both the surgery and the post-surgical treatment and was not negligent. Perhaps all that a court can do is analyze whether the available "scientific means and facilities" were used with the intelligence and concern expected of a reasonably competent doctor.

Probably the best known case of liability of misdiagnosis is that of Vancouver General Hospital v. Fraser²⁵² where two interns in the emergency department examined an accident victim, misinterpreted his x-rays and sent the patient home, missing the diagnosis of a dislocated fracture of the neck. Upon analysis, it seems that their skill at reading x-rays

251. Hobson v. Munkley (1976) 1 C.C.L.T. 163 (Ont. H.C.).

252. Vancouver Gen. Hospital v. Fraser supra n. 70 and Hôpital Notre Dame de l'Espérance v. Laurent [1978] 1 S.C.R. 605.

and their judgment in ignoring the patient's complaints were inadequate because of inexperience. The answer, and the court so held, would have been to refer the case to the specialist on call for assistance in diagnosis.

A doctor missed a "text book" diagnosis in an early Saskatchewan case.²⁵³ The symptoms the experts said were clearly of "an abscess in the lumbar region" (an abscess of the kidney from a stone in it), but the doctor diagnosed "rheumatism of the sciatic nerve or neuritis", and was held liable for failing to meet his standard of care in diagnosis. The patient suffered under this misdiagnosis for over a month, and the judge remarked:²⁵⁴

When a medical man finds that his treatment, after fair trial, does not assist the patient, one wonders that he is not willing to nobly admit defeat and advise the calling in of someone who may be more expert. Such a course would not, it seems to me, be at all humiliating, and in any event no man with a proper appreciation of the value of a human life should hesitate for a moment to adopt it.

Clearly, discharging the duty to diagnose sometimes means admitting defeat and seeking assistance.

However, of the reported cases, far more tell of doctors exonerated than held liable. Perhaps the best known Canadian case is the often quoted Wilson v. Swanson²⁵⁵ where a surgeon made a diagnosis of cancer prior to an operation and during surgery received a pathologist's report

253. Turriff v. King *supra* n. 135.

254. Id. at 678.

255. [1956] S.C.R. 804.

that confirmed the probability. On the basis of this diagnosis, he proceeded to do radical surgery. The diagnosis was wrong, and the plaintiff brought action alleging that further tests ought to have been done. The Supreme Court of Canada²⁵⁶ disagreed, because the tests suggested would not have been any surer a guide to the exercise of judgment than those upon which the surgeon relied. In an English case²⁵⁷ with similar facts it was held not to be negligence to misdiagnose cancer although the use of a diagnostic tool rare in England would have enabled a more certain diagnosis.

A patient suffering from pain, weakness, menstrual abnormality and a mass in the uterus submitted to an exploratory operation performed by her family doctor and a gynecologist.²⁵⁸ They had misdiagnosed her condition (she was pregnant and later had a normal child). She brought action, but the court relied on expert evidence that her symptoms could have indicated an ectopic pregnancy, a fibroid tumour or ovarian cancer, and pointed out that an error in diagnosis does not mean an error in medical judgment.

Another case²⁵⁹ did not end so happily for the patient whose symptoms were tiredness, dizziness, frequent urination accompanied by burning and difficulty in breathing and walking. She died of a "haemorr-

256. The Court of Appeal (1956) 2 D.L.R. (2d) 193 had agreed with the plaintiff.

257. Whiteford v. Hunter *supra* n. 121; see *supra* s. 2.(b)(ii)C. of this chapter. See also Pudney v. Union-Castle Mail SS. Co. [1953] 1 Lloyd's Rep. 73 (Q.B.).

258. Finlay v. Hess (1973) 44 D.L.R. (3d) 507 (Ont. H.C.).

259. Serre v. de Tilly *supra* n. 193.

hage in the lower brain stem and upper cervical cord from an unknown cause". The court held that the doctor's diagnosis of hysteria was consistent with her symptoms at the time of the examination. The fact that another doctor might have made a different finding or that a blood test would have indicated a possible platelet defect did not fix the doctor with negligence.

A doctor engaged to look after workers at a camp in 1927 diagnosed skin eruptions as the after-effects of influenza or as erythema.²⁶⁰ Later, a health officer diagnosed them as mild cases of smallpox with an unusual rash, but expert evidence indicated that without the appearance of a typical lesion, smallpox is difficult to diagnose, and the court held the doctor not liable. A doctor in 1960 diagnosed a child's condition as an acute upper respiratory infection.²⁶¹ Her condition deteriorated and she suffered a convulsion followed by cessation of breathing and serious brain damage. Experts examining the symptoms in retrospect could not agree on the diagnosis or cause of the child's injury. Two agreed it was probably encephalitis with a degree of epiglottitis, while another thought it was due to epiglottitis alone. All agreed that epiglottitis, a rare disease, would not have been known in 1960 to a general practitioner, and the defendant's diagnosis and follow-up care was held to have met the standard expected of him.

Another general practitioner escaped liability in 1964 for failing to diagnose carbon monoxide poisoning.²⁶² His diagnosis was influenza,

260. Hamilton v. Phoenix Lbr. Co. [1931] 1 W.W.R. 43 (Alta. C.A.).

261. Tiesmaki v. Wilson *supra* n. 38.

262. Ostash v. Sonnenberg *supra* n. 41.

which was prevalent at the time, and the court held that in all the circumstances, the doctor could not have been expected to detect an odourless, deadly gas, in spite of the fact that a specialist and the chief coroner were definitely of the opinion that the doctor should have considered carbon monoxide poisoning. Another general practitioner also testified saying that he had rarely seen such cases. A doctor who²⁶³ failed to diagnose mastoiditis was chastised by the court which said that he was not prudent in stating so confidently that there was no mastoid trouble when he was unable to make a diagnosis. He was, however, held to have met the required standard of care. It was also suggested that he might have admitted defeat and called in a specialist although at that time there was found to be no duty to do so.²⁶⁴

In a very recent case, a doctor's diagnosis of gastroenteritis where the patient had meningitis was held not negligent,²⁶⁵ in spite of his failure to test for what the experts testified were two classic symptoms: headache and stiff neck. The court found that these were either absent or not reported to him and found his diagnosis to be proper, but held him liable for his failure to hospitalize a very sick man. It appears that this case reached the just result of liability for the wrong reasons. The evidence indicated that when the doctor saw the patient, there were symptoms more severe than those associated with the viral infection. The doctor had also been alerted to the fact that the patient

263. Jarvis v. Internat. Nickel Co. *supra* n. 56.

264. There is now a duty to refer. See infra.

265. Dale v. Munthali *supra* n. 54. See also Sadler v. Henry [1954] 1 Brit. Med. J. 1331; Vachon v. Moffett (1911) 40 S.C. 166 (Que.).

had no spleen which, according to the evidence, is a condition rendering a patient more vulnerable to the disease. Yet the doctor neither carried out the simple tests nor inquired about headache. Furthermore, his scanty notes included only the patient's name, health care number and the incorrect diagnosis.

A doctor's role in diagnosis cannot be just a passive one. Within reason, if simple tests are indicated they should be carried out; if certain symptoms could be critical they should be canvassed.

Even specialists, who have to meet a higher standard, may not be liable for a failure to diagnose.²⁶⁶ An orthopedic surgeon who diagnosed a "slipped disc" and operated was satisfied that the operation was successful and that the patient would be relieved of his prior symptoms. Recovery was not as expected, however, and a second operation was performed by a neurosurgeon who discovered "a large chunk of extruded disc material" in the area. The patient sued the orthopedic surgeon for failure to diagnose, locate and remove this material in the first operation. The evidence left some doubt as to whether the extrusion found in the second operation was present during the first but the trial judge held that even if it was, the doctor as a specialist had met his standard of care in the diagnosis and surgery. Regarding the diagnosis, he examined the patient, tested extensively and arrived at a reasonable diagnosis.

The tests that a doctor is expected to carry out are only those in common practice.²⁶⁷ A doctor in 1932 was held not liable for missing

266. Lepp v. Hopp (1977) 2 C.C.L.T. 183; reversed on the consent issue, (1979) 8 C.C.L.T. 260 (Alta. C.A.).

267. Moore v. Large *supra* n. 20.

the diagnosis of a dislocated shoulder. All of the normal tests were consistent with his diagnosis of sprain but an unusual congenital defect in the patient led to the incorrect diagnosis. An x-ray would have exposed the problem but was not in common use and was expensive for the patient, and the doctor's failure to use it was not negligence.

In summary, the duty to diagnose requires a doctor to take a full history, use tests in common use and consult or refer if necessary. He must take reasonable care to detect signs and symptoms and formulate a diagnosis using good judgment. He cannot act only on what he is told; sophisticated tests and continuing knowledge of disease must be employed when appropriate. His skill and judgment must be in step with that of his colleagues but need not be advance of their's, and if he meets this standard of care in the circumstances he will not be held liable to a patient injured by his misdiagnosis.

(c) The Duty to Refer

Recognizing that no person is infallible nor master of all knowledge and skill, the Supreme Court of Canada has said there is a duty upon a doctor in some circumstances to refer a patient to another doctor.²⁶⁸ The term "refer" may mean either that the doctor confer with a colleague and then carry on treatment himself, or that the patient is passed completely into the care of another doctor.

268. Vail v. MacDonald *supra* n. 44; Ares v. Venner [1970] S.C.R. 608. Earlier authority to the contrary, namely, Jarvis v. Internat. Nickel Co. *supra* n. 56 is overruled. See also Nathan, *supra* n. 19 at 46; Sherman, *supra* n. 32.

There is no absolute test to ascertain when a doctor should refer or consult, but the cases suggest that it is indicated when:²⁶⁹

- i) the doctor is unable to diagnose the patient's condition²⁷⁰
- ii) the patient is not responding to the treatment being given²⁷¹
- iii) the patient needs treatment which the doctor is not competent to give²⁷²
- iv) the doctor has a duty to guard against his own inexperience (e.g. the student doctor)²⁷³
- v) the doctor cannot continue to treat a patient (e.g. while on vacation).²⁷⁴

A critical factor in the duty to refer is the timing. How soon must the counsel of a colleague be sought? In a large hospital or an urban setting this step may be simply and expeditiously taken. Indeed, in a large teaching hospital it will be common. However, a rural general practitioner may have to balance many factors such as his ability, available equipment and facilities, the patient's prognosis, the distances involved and the effect of a move on the patient before sending the

269. Chipps v. Peters *supra* n. 64.

270. See supra n. 268.

271. Turriff v. King *supra* n. 135.

272. Bell v. R. *supra* n. 104; Kunitz v. Merei [1969] 2 O.R. 572 (H.C.).
See also Canadian Medical Protective Association, Annual Report 1976 at 13 where it is stated: "Do only the work for which you are trained; refer work you cannot or should not do to someone who can".

273. Fraser v. Vancouver Gen. Hospital *supra* n. 70; Daoust v. R. [1969] D.R.S. 594 (Ex. C.C.).

274. Wilson v. Stark *supra* n. 43; Re Lesk [1947] 3 D.L.R. 326 (B.C.S.C.); Bergstrom v. G. [1967] C.S. 513 (Que. S.C.).

patient to another doctor. Nonetheless, advice and the opportunity to collaborate with a colleague can be achieved quickly by telephone. The cases indicate that the courts realize that it is easy to be wise after the fact and so long as the referral is made within a reasonable time no liability has followed. In a case where the patient had polyps removed by an otolaryngologist there was extensive bleeding and twenty-four hours later her eye was swollen, bruised and bulging. The next day it was worse and the patient complained of loss of sight so the doctor referred her to an ophthalmologist but he could not see her for six hours. One expert testified he would have acted on the symptoms more promptly but the otolaryngologist was held not liable for the permanent loss of vision in the eye.²⁷⁵ On the other hand, a surgeon who failed to confer for twenty days while his patient showed clear signs of circulatory impairment was held liable for a failure to refer.²⁷⁶

Overlaps between the limits of professional competence cause difficulties for the courts who must depend on expert evidence to set the boundaries. In a case²⁷⁷ where a general surgeon removed a patient's uterus and did "repair work to improve her bladder condition and stop the protrusion of her organs", the patient argued that she should have been referred to a gynecologist. The trial judge and the Court of Appeal were not in accord, however, because of the equivocal nature of the expert evidence as indicated by these words:²⁷⁸

275. Kunitz v. Merei *supra* n. 272; see also Bell v. R. *supra* n. 104.

276. Vail v. MacDonald *supra* n. 44.

277. Chipps v. Peters *supra* n. 64.

278. Id. at 8.

While it is true that a surgical procedure such as that undertaken here would not have been carried out by a general surgeon in the major teaching hospitals in Toronto and London, but would have been performed by a specialist in gynaecology, nevertheless the evidence did not go so far as to establish that the surgery was beyond the sphere of the competence of a general surgeon. Indeed there was evidence to the contrary. Dr. Morgan, who is a specialist of the highest qualification, and whose extensive responsibilities include the training of general surgeons insofar as procedures in gynaecological matters are concerned, established that there is a role for the general surgeon in this field, and that surgery such as that in question is performed by general surgeons.

The standards set by the courts in regard to competence and division between specialities can only be as clear or certain as the medical profession itself is on the matter.

Although arrangements for a patient's care during a doctor's absence, for example during vacation, have often been made casually, the persistence of patients and courtesy of colleagues has rarely resulted in liability being found in Canada on the basis of abandonment,²⁷⁹ which is a failure to refer at its most extreme.

(d) The Duty to Treat

(i) Quality of care

A doctor who has undertaken the attendance and diagnosis of a patient, perhaps with consultation, has a duty to treat the patient. The

279. Re Lesk supra n. 274; Wilson v. Stark supra n. 43. But see Bergstrom v. G. supra n. at 274. See also Canadian Medical Protective Association, Annual Report 1975 at 15 for a case where liability was admitted.

best medical care is as individualized as the human beings it involves; indeed, it is the essence of medical care that the care a patient receives be unique to him. Adversarial relationships between doctor and patient often stem from the patient's complaint that the doctor did not deal with him, that he was just another "gall bladder" or "neurotic". Reactions of some doctors to these complaints include: a doctor cannot get personally involved with his patient, the less said to the patient the better, or a doctor would spend all his time talking instead of operating. These physicians miss the point. The essence of a professional relationship, especially the doctor-patient relationship, is care and communication. The absence of this rapport is always found somewhere in the facts of a case that is litigated, which the Canadian Medical Protective Association regularly points out to the membership in the Annual Reports.²⁸⁰

It is not feasible to discuss under this heading every case in which it has been alleged that a doctor was negligent in his treatment of a patient. Covered here are only the most litigious areas and troublesome cases. The section discusses surgical and anaesthetic mishaps, problems with drugs and injections, and complications from casts.

(ii) Surgery

Many law suits have been commenced as a consequence of surgical mishaps and as the basic principle of all negligence law has been applied in

280. See, for example, Canadian Medical Protective Association, supra n. 272 at 11.

them it is, perhaps, worth repeating. Any doctor who undertakes the surgical treatment of a patient must, in doing so, meet the standard of care of a reasonable medical man considering all the circumstances.

The cases indicate that surgical problems coming before the courts fall into three categories: 1) surgery more extensive than necessary; 2) damage to other tissue or organs; and 3) objects left inside the body. Anaesthesiological mishaps are also common but are dealt with separately.

In the mistaken belief that an ulcer patient was suffering from cancer, a doctor removed "large portions of the plaintiff's stomach, pancreas and the entire spleen".²⁸¹ The doctor was exonerated because he had met the standard of care in his reliance on a pathologist's report and his pre-surgical diagnosis was reasonable. But the surgeon who operated on the wrong leg of a polio victim²⁸² and the surgeon who fused the wrong cervical vertebrae²⁸³ could not be said to have acted as reasonable surgeons in the circumstances, and were held liable.

Accidental injury during surgery has often been a subject of litigation. While removing an infected cyst, a surgeon damaged the patient's spinal accessory nerve and in the light of the expert evidence was held liable,²⁸⁴ as was a surgeon who severed a nerve when operating on a patient's wrist.²⁸⁵ The evidence of negligence was irrefutable in

281. Wilson v. Swanson *supra* n. 255. See *supra* s. 2.(b) of this chapter.

282. Staple v. Winnipeg *supra* n. 168.

283. David v. T.T.C. *supra* n. 225.

284. Fizer v. Keys [1974] 2 W.W.R. 14 (Alta. S.C.).

285. McKeachie v. Alvarez *supra* n. 50.

another case where a second operation showed the wall of the patient's bladder to have been "tied into" a hernia repair done by the first surgeon who had accidentally cut and then sutured it.²⁸⁶ That even a "simple and common" procedure may hold risks for the doctor and patient was borne out where the surgeon removing polyps from the patient's nose caused a retrobulbar haemorrhage.²⁸⁷ The action was dismissed because the otolaryngologist had met the standard of care to be expected of him. A surgeon who damaged a patient's ureter while doing a tubal ligation was held not liable because there was no evidence to support the allegation.²⁸⁸ The action was also dismissed against a surgeon carrying out an inherently more dangerous procedure which caused the death of the patient; in removing a disc, the orthopedic surgeon lacerated the aorta and the vena cava.²⁸⁹

The story of objects lost and found during surgery is an old one. One authority²⁹⁰ has said "the danger of swabs being overlooked at the end of an abdominal operation is a very real and grave one and in consequence extraordinary precautions are commonly taken in an attempt to reduce this risk as far as possible". Most of the reported cases occur-

286. Melvin v. Graham [1973] D.R.S. 659 (Ont. H.C.).

287. Kunitz v. Merei *supra* n. 272; see also Canadian Medical Protection Association, *supra* n. 272 at 14.

288. Hobson v. Munkley *supra* n. 251.

289. Chubey v. Ahsan *supra* n. 90; see also Kapur v. Marshall (1978) 4 C.C.L.T. 204 (Ont.).

290. Nathan, *supra* n. 19 at 78.

red during the period from 1920 to 1950.²⁹¹ The precautions employed included the use of sponge with tapes attached, sponge counting systems and vesting the surgeon with a residual duty to ensure that nothing was left behind. In two Canadian cases a doctor²⁹² and dentist²⁹³ were held to be negligent when their patients died by suffocation on a sponge left behind after a tonsillectomy and asphyxia from a gauze swab left after dental extractions. While modern surgical practice and the system of assigning a nurse to count sponges has reduced the risk of sponges and other foreign material being left in the body, it still occurs on occasion.²⁹⁴

When surgical instruments are left behind in the patient's body liability does not necessarily follow. In a case from New Zealand²⁹⁵ in which a pair of forceps was discovered in the patient's abdomen after surgery, expert evidence indicated that they probably slipped in because it was the surgeon's habit to place instruments on the patient's chest but that this practice was "usual and proper". Similarly, in two early

291. See Jewison v. Hassard *supra* n. 9; Waldon v. Archer (1921) 20 O.W.N. 77 (H.C.); Van Wyck v. Lewis *supra* n. 10; James v. Dunlop [1931] 1 Brit. Med. J. 730. A thorough discussion of the "swab" cases appears in Nathan, *supra* n. 19 at 77-86.

292. Anderson v. Chasney *supra* n. 18.

293. Holt v. Nesbitt [1953] 1 D.L.R. 671 (S.C.C.).

294. Karderas v. Clow *supra* n. 8; see also Radclyffe v. Rennie *supra* n. 174 where the issue was whether gauze found in the patient's body in 1961 had been left in, in 1944 or 1959 on the occasions of previous surgery.

295. MacDonald v. Pottinger [1953] N.Z.L.R. 196 (S.C.).

Canadian cases where a tube was left in an incision²⁹⁶ and a portion of a broken forceps was left behind²⁹⁷ there was no liability. In the first case it was the nurse who was held negligent and in the second no injury was proven to have been caused by the foreign body. However, surgeons were held liable in two later cases. In a New Brunswick case²⁹⁸ seven months after a Caesarian operation "an Allis forceps five and three quarter to five and seven eighth inches long and two inches broad at the ends", was removed from over the right kidney of the patient, and the surgeon was held to have breached the standard of care expected of him. In an Alberta case,²⁹⁹ a surgeon used his own instruments in performing a Caesarian section, and five years later the patient required surgery to retrieve the doctor's Kelly forceps (about six inches long) which had been left in her abdomen. The surgeon was held negligent.

(iii) Anaesthesiology

Anaesthetic mishaps can both occur very quickly and result in serious injury to the patient. The Canadian Medical Protective Association has advised its membership:³⁰⁰

296. Thompson v. Barry [1932] 1 D.L.R. 805; reversed [1932] 2 D.L.R. 814 (Ont. C.A.).

297. Hutchinson v. Robert *supra* n. 182.

298. Taylor v. Gray (1937) 11 M.P.R. 588 (N.B.C.A.).

299. Gloning v. Miller (1953) 10 W.W.R. 414 (Alta. S.C.).

300. Canadian Medical Protection Association, *supra* n. 272 at 12.

The complexities of modern anesthesia nowadays demand not only the undivided attention of the doctor administering the anaesthetic but also that the anaesthetist have the knowledge, skill and experience to recognize and deal promptly with complications which may arise insidiously or suddenly and unexpectedly.

As well it has counsel against the occasional practice of anaesthesiology:³⁰¹

It is still widely accepted in Canada that doctors need not necessarily possess specialist certification in order to practice anaesthesia safely and completely. This notwithstanding, nowadays it must be appreciated that anaesthetic work is not for the occasional anaesthetist who may be lacking in detailed knowledge of the pharmacology of patent and dangerous anaesthetic agents and who may have only infrequent opportunities for the necessary experience in their use. From the medico-legal standpoint such deficiencies can be unacceptable.

The cases bear out the warnings. The Supreme Court of Canada has twice heard cases against anaesthetists and found them liable. In one case³⁰² an explosion resulted from the doctor's negligence in leaving the oxygen flowing on an ether can while the Magill tube (a small tube introduced into the trachea) was not connected to it. A spark of static electricity set the oxygen-ether mixture aflame. The Court of Appeal³⁰³ found a breach of the high standard of care expected because

301. Id. at 14.

302. Crits v. Sylvester *supra* n. 1; see also Paton v. Parker *supra* n. 7.

303. Crits v. Sylvester *id.*

of the handling of dangerous agents. In the second case³⁰⁴ an anaesthetist administered a caudal anaesthetic comprised of Xylocaine added to adrenalin. Serious inflammation of the spinal cord resulted in permanent paraplegy. The expert evidence was that the paralysis would not normally follow the proper administration of a caudal anaesthetic and the defendant's hypothesis that the patient had a sensitivity to the drugs used was rejected. The result for the patient was as insidious here as it was sudden in the first case.

The complexities of modern anaesthesia are underscored in two other cases. During the preliminaries to an "open heart" operation, a stopcock was not completely turned off allowing air into the venous system of the patient who was thereby seriously injured. The court commented on the great danger to the patient if air passed through the line and on the failure to utilize the means and methods known and available to eliminate the danger. Both the anaesthetists required on this sophisticated procedure were held liable. In a very recent case³⁰⁵ a patient became a quadriplegic when an anaesthetist using a new method of artificial ventilation, "transtracheal ventilation," deviated from the practice laid down by its inventor with the result that the patient suffered from

304. Martel v. Hôtel-Dieu St-Vallier (1969) 14 D.L.R. (3d)445 (S.C.C.); see also Walker v. Bedard [1945] O.W.N. 120 (H.C.) where the patient died from the effect of Nupercaine, a spinal anaesthetic, and Sisters of St. Joseph v. Villeneuve [1975] 1 S.C.R. 285 where a child lost his right hand from a misplaced pre-operative anaesthetic. See also Roe v. Minister of Health supra n. 78; Jones v. Manchester Corpn. [1952] 2 All E.R. 125 (C.A.).

305. Holmes v. Bd. of Hospital Trustees of London supra n. 16. Note that two other doctors were held liable for their negligence in contributing to the injuries suffered.

massive tissue emphysema. Negligence was found and the damages awarded at trial were over \$700,000.

Tragedy occurred³⁰⁶ when a patient misled an anaesthetist about his fluid intake prior to surgery from ingrown toenails. Difficulties were encountered in anaesthetizing the patient because he had laryngeal spasms and regurgitated into the lungs. Death ensued after a cardiac arrest, but the anaesthetist was not held liable; he had no duty to interrogate the patient.

The standard of care expected of any doctor is affected by the risks involved. Clearly, in anaesthesiology the risks are high and it follows that the standard of care is high. Furthermore, the extensive injury often suffered by the patient means that the compensation required is large. Anaesthesia is an area of high risk: for the patient of injury, for the doctor of liability.³⁰⁷

(iv) Drugs and injections

The use of a drug always involves risk. It may be the possibility, albeit remote, of an allergic reaction by the patient, or it may be the choice of the wrong drug or carelessness in its administration. The

306. Webster v. Armstrong [1974] 2 W.W.R. 709 (B.C.S.C.).

307. See Gorback v. Ting [1974] 5 W.W.R. 606 (Man. Q.B.) where the injury was a chipped tooth, no liability; Kangas v. Parker supra n. 55 where the injury was death, liability. Girard v. Royal Columbian Hospital supra n. 175; see also Canadian Medical Protective Association, supra n. 272 at 12 and 16. Note that another high risk area, the recovery room, is discussed in Chapter 10.

future might even see actions for a failure to treat with drugs.³⁰⁸

The standard of care is elevated by the greater risks in this area, but liability is not automatic. The requirements for the finding of negligence must as always be proven by the plaintiff,³⁰⁹ and because of the complexities of pharmacology and physiology it may be difficult to prove the causal link between the drug and the injury,³¹⁰ even with the assistance of the evidentiary doctrine of res ipsa loquitur.

Cases dealing with an adverse reaction to a drug are illustrative of this difficulty. A doctor was held not liable when the victim of a dog bite suffered a toxic reaction to an anti-tetanus shot.³¹¹ The expert evidence was that the reaction was extremely rare and the doctor had met his standard of care in administering the injection which, while it was the cause-in-fact of the serum neuritis, was not held to be the proximate cause. The owner of the dog was held liable, though, as the patient was found to be a thin-skull person and thus an exception of the foreseeability rule.³¹² The same hurdle, that of a reaction so rare as not to be reasonably foreseeable, precluded recovery by a patient who was hypersensitive to Nupercaine³¹³ and one who went beyond the desired state of

308. See Parsons v. Schmok *supra* n. 111 where the plaintiff unsuccessfully alleged that anti-hypertensive drug therapy could have averted his stroke. See also Vail v. MacDonald *supra* n. 44.

309. See *supra*.

310. Webster v. Armstrong *supra* n. 306.

311. Winteringham v. Rae and Robinson v. Post Office *supra* n. 194.

312. See *supra*.

313. Walker v. Bedard *supra* n. 304; see also Martel v. Hôtel-Dieu *supra* n. 304 where the hypersensitivity argument was rejected.

drowsiness to unconsciousness from treatment with Thorazine.³¹⁴

If tests are available or suggested in conjunction with drug therapy the standard of care may require that they be carried out. It was important in the anti-tetanus cases where preliminary tests were done,³¹⁵ and a doctor who failed to conduct hearing tests as suggested by the manufacturer during massive doses of neomycin was liable to the patient who suffered a permanent hearing loss.³¹⁶ Similarly, a patient who was allergic to penicillin was successful in a suit against a doctor who neither inquired nor checked her records prior to giving her an injection of procaine penicillin.³¹⁷ In a very recent case³¹⁸ the patient was treated with chloroquine for a skin disorder by her doctor who referred her to an ophthalmologist after reading that it could cause permanent loss of vision. However, the doctor did not read carefully enough the ophthalmologist's report which indicated corneal changes. The judge said that "...the standard of care, having regard to the inherent dangers involved in the use of the drug, must of necessity, be very high." and held the doctor negligent.³¹⁹

314. Buchanan v. Fort Churchill Gen. Hospital [1969] D.R.S. 586 (Man. Q.B.).

315. Supra n. 194.

316. Male v. Hopmans supra n. 85.

317. Chin Keow v. Government of Malaysia [1967] 1 W.L.R. 813 (P.C.).

318. Crossman v. Stewart supra n. 83.

319. Id. at 56. Note that the patient was held two-thirds to blame because she had been obtaining drugs from a salesman after her prescription ran out.

An error in the administration of a drug, be it the wrong drug, the wrong dosage, or a misplaced injection, often results in liability. Mistakes as to drug or dosage are often patent while the misplaced injection may be more difficult to prove especially in terms of causation.

Liability has been found in a number of wrong drug cases. In a very old one in Quebec the doctor wrote "bi-sulphate of morphine" instead of "bi-sulphate of quinine" in a prescription for a child, who died from it.³²⁰ In a modern cases,³²¹ a doctor doing a minor operation on a thumb intended to inject Novocain but in error injected adrenalin. The patient died. In a remarkably similar fact situation five years earlier³²² which also resulted in the patient's death a doctor setting a thumb asked for Novocain but was given adrenalin by the nurse. It was found that the doctor could rely on the nurse and was not negligent, but the nurse and hence the hospital were held accountable. Considering the extreme consequence to a patient it might be preferable to require a doctor also to check the label under such circumstances.³²³ Liability has followed the administration of an excessive dose or the wrong drug in

320. Jeanotte v. Couillard (1894) 3 R.J. 461 (Que. Q.B.). The pharmacist had substituted sulphate of morphine but it was held bi-sulphate of morphine would have had the same effect. He was held one-sixth at fault and the doctor five-sixths at fault.

321. Pollard v. Chipperfield (1952) 7 W.W.R. 596 (Sask. C.A.).

322. Bugden v. Harbour View Hospital *supra* n. 13.

323. Nathan, *supra* n. 19 at 60. This would be consistent with the residual duty to check the operating area for foreign material left. See supra.

a number of English cases as well.³²⁴

Where an injection is misplaced or a needle broken negligence has sometimes been found. When vaccinating a young girl a doctor chose an inner rather than an outer aspect of the arm and when she suffered "multiple takes" of the vaccine and a secondary infection, she sued but was unsuccessful.³²⁵ The expert evidence was that the area chosen was acceptable, that the standard of care had been met, and in any event the vaccination was not the proximate cause of the infant's suffering. By contrast an anaesthetist in another case³²⁶ was held liable where a young boy was restrained while he attempted to inject pentothal into a vein but instead injected it into an artery, which caused the child's eventual loss of his right hand. In another case the patient did prove that he lost fingers and a thumb as a result of bicillin getting into an artery and that a nurse had given him an injection of bicillin but the Supreme Court of Canada³²⁷ said the nurse had discharged the evidentiary burden resting on her by showing that the misfortune suffered by the patient could have occurred without negligence on her part. The Court of

324. Strangeways-Lesmere v. Clayton [1936] 1 All E.R. 484 (K.B.D.); Collins v. Hertfordshire County Council [1947] 1 All E.R. 633 (K.B.D.); Jones v. Manchester Corpn. [1952] 2 All E.R. 125 (C.A.). See Nathan, supra n. 19 at 58-59.

325. Gent v. Wilson [1956] O.R. 257 (C.A.).

326. Sisters of St. Joseph v. Villeneuve supra n. 304; see Armstrong v. McClelland (1930) 38 O.W.N. 297 where no liability followed the transfusion of blood into an artery when the attempt had been to put it inside a vein; see also Caldeira v. Gray [1936] 1 All E.R. 540 (P.C.).

327. Cavan v. Wilcox (1974) 2 N.R. 618 (S.C.C.); see also Hughston v. Jost [1943] 1 D.L.R. 402 (Ont. S.C.).

Appeal³²⁸ had held her liable, saying her story that she must have followed a particular technique but did not specifically remember this case was not sufficiently convincing. It seems clear that the injection was the cause-in-fact of the injury but the courts differed on whether it ought to have been regarded as the proximate cause.

Similarly when the injury to the patient occurs from a broken needle the issue of foreseeability of risk of harm has been the decisive factor. In a Quebec case³²⁹ that went to the Supreme Court of Canada a young boy resisted an injection but the doctor insisted on proceeding over the protests of the mother. Upon the prick of the needle the boy moved his arm and a portion of the needle broke underneath the skin necessitating three operations and causing temporary paralysis and permanent scars. The Court said the cause of the injury was the injection which the doctor chose to administer in spite of the risk. On the other hand, in another Quebec case³³⁰ a needle broke in a dental patient's jaw, and the court held that the dentist met the standard of care by using the same type of needle others used. Obviously the court felt that in this instance a breaking needle was not foreseeable. The use of disposable needles has removed the risk of fracture from use. However, the cases show that the risk of fracture from movement remains especially where children are involved. Should a doctor experience such an accident he has a duty to

328. Cavan v. Wilcox *supra* n. 232.

329. Cardin v. Montreal *supra* n. 29.

330. Bouillon v. Poire (1937) 63 Que. K.B. 1 (C.A.); see also Gerber v. Pines (1935) 79 Sol. J. 13 (K.B.); Hunter v. Hanley [1955] S.L.T. 213 (1st Div.); Mitchell v. Dixon *supra* n. 247. Nathan, *supra* n. 19 at 57.

inform the patient of what has occurred.³³¹

The administration of drugs involves a range of potential liability for the doctor and difficulty of proof for the patient. At one end are the cases involving wrong drugs or dosages and broken needles in children, where proof is easy and liability likely. At the other end are cases involving adverse reaction to drugs, where proof of causation is especially difficult and the doctor can meet his standard of care by following approved practice and testing the patient for allergies or known side-effects.

(v) Casts

Complications following treatment with casts have received a great deal of attention in Canadian courts. The Supreme Court of Canada has within the last decade heard three major cases and found the doctors liable.³³² Of these three cases two involved circulatory impairment and one an infection following insertion of an intramedullary nail.³³³ There are surprising similarities among the three cases. All involved a closed reduction of a fracture with symptoms following that made it clear all was not well. In each, the evidence was that the patient's deteriorating condition was ignored and the doctor's follow-up treatment was

331. Hutchinson v. Robert [1935] O.W.N. 172 at 176; reversed [1935] O.W.N. 314 (C.A.) with no reference to this point.

332. Ares v. Venner supra n. 44; McCormick v. Marcotte supra n. 26; Vail v. MacDonald supra n. 44.

333. McCormick v. Marcotte supra n. 26.

described variously as "inept",³³⁴ "neglectful"³³⁵ or "concerned more with maintaining the good fracture reduction...than with the maintenance of good circulation."³³⁶ A failure to consult or refer was found in each case and a failure to bi-valve the cast or prescribe anti-coagulants was found in two.³³⁷ Two patients suffered amputations and the third serious permanent damage. Unheeded circulatory problems can lead to loss of limbs, and the seriousness of this risk has moved the courts³³⁸ to impose a common standard of care on all doctors whose treatment of a patient raises this risk. It should be recognized that this formulation of the standard of care is a departure from the norm which bases the standard of care primarily on the qualifications of the doctor. It also indicates the magnitude of the risk for patients as perceived by the courts.

Other cases worth noting also have these apparently common features to varying degrees. In a Saskatchewan case³³⁹ a patient suffered fractures of both legs, and after casts were applied he complained of pain and nurses' notes indicated the feet were cold and numb and the toes were cyanotic. After 36 hours the casts was univalved (cut down one

334. Id. at 22.

335. Vail v. Macdonald *supra* n. 44 at 531.

336. Ares v. Venner *supra* n. 44 at 615.

337. Ares v. Venner and Vail v. MacDonald both *supra* n. 44.

338. See O'Byrne J. at Alta. S.C.T.D. in Ares v. Venner; affirmed in [1970] S.C.R. 608 at 614 and in Vail v. MacDonald *supra* n. 44 at 534.

339. Badger v. Surkan *supra* n. 45; see also Park v. Stevenson Memorial Hospital *supra* n. 220.

side) and the next day bivalved, but it was too late; both legs had to be amputated. The doctor was held negligent in the follow-up treatment. In another case³⁴⁰ a woman was put in a cast for a "chronic draining sinus" and sent home. Motivated by pain she tried to contact the doctor but, it being a holiday weekend, four days passed before her calls were returned. The doctor removed the cast two days after that, but she was suffering from gangrene and her leg was amputated. The court found the doctor was negligent by failing to make proper arrangements for checking the patient during the weekend, and by failing to see her earlier.

In a Manitoba case³⁴¹ a patient broke her ankle in a fall and the intern who x-rayed it found a simple transverse fracture with no displacement. He taped on a plastic slab and the defendant doctor put on a walking cast the next day but took no further x-rays. Expert evidence was that a second x-ray should have been taken to ascertain if any displacement occurred in the interim. After 18 days of "excrutciating pain" an x-ray was taken which showed a displacement of at least one half an inch, which led to the patient's having a deformed ankle. It was held that the doctor had failed to meet the standard of care by not taking an x-ray prior to applying the cast.

340. Bergstrom v. G. supra n. 20.

341. Parkin v. Kobrinsky supra n. 117. See also Moore v. Large supra n. 20 where it was held not negligent to fail to take x-rays. The standard of care changed in the 33 years between these cases. See also Price v. Milawski supra n. 117.

(e) To Instruct the Patient

It may be necessary for the doctor to delegate certain duties of the medical treatment to the patient or his family. Most doctors depend on the patient to report some symptoms or details of the progress of treatment, and in these circumstances, the patient has a duty to act reasonably in his own welfare.³⁴² His failure to do so may prejudice any claim he may have against the doctor.

The question is whether it is reasonable in the circumstances for the doctor to shift responsibility to the patient. There is no doubt that it is so where the duties are those a reasonable person could be expected to carry out, such as taking drugs as prescribed,³⁴³ refraining from eating or drinking for a limited time,³⁴⁴ or returning for treatment as requested³⁴⁵ or as required.³⁴⁶ In 1912 there was a case³⁴⁷ where the medical evidence was in conflict as to whether it was reasonable for the doctor to rely on an infant patient's mother to notify him of a displacement of a fracture. The patient was a young child of a poor family

342. See infra Chapter 6.

343. Crossman v. Stewart *supra* n. 83.

344. Webster v. Armstrong *supra* n. 306; Barsy v. Govt. of Man. (1966) 57 W.W.R. 169 (Man. Q.B.).

345. Ostrowski v. Lotto (1972) 31 D.L.R. (3d) 715 (S.C.C.); Moore v. Large *supra* n. 20.

346. Murrin v. Janes *supra* n. 218.

347. Rickley v. Stratton (1912) O.W.N. 1341 (Ont. H.C.); see also Town v. Archer (1902) 4 O.L.R. 383 (K.B.) where the patient herself relaxed the bandages with similar consequences.

living a considerable distance away on very poor roads. But there was a telephone in the town, which the patient's parent could use to contact the doctor. The leg was well bandaged in splints, and the mother was thoroughly instructed, so the doctor left the patient to the mother's care. There were further visits by the doctor but also evidence that the mother interfered with the weights on the apparatus in order to relieve the child's pain. Eventually, due to misunion, an operation was necessary but again because of the mother's failure to obey the doctor's instructions the child finished with a deformed leg. It was held that the doctor was reasonable in his reliance on the mother.

When the doctor delegates to the patient the performance of some part of the treatment, there is a duty on the doctor to explain clearly what is expected of him and to warn him as may be required by the circumstances. As was said in an early case:³⁴⁸

... where, in the nature of the case the doctor cannot perform the service himself, he is bound to give such instructions as will enable an ordinary person to follow his directions; and, if he failed to do so and injury resulted to the patient therefrom, he would be guilty of actionable negligence.

In another early case, quoted with approval by Meredith³⁴⁹ a judge warned:³⁵⁰

348. McQuay v. Eastwood *supra* n. 112 at 410.

349. Meredith, *supra* n. 9 at 88.

350. Town v. Archer *supra* n. 347 at 389.

The failure on the part of a medical man to give a patient proper instructions as to the care and use of an injured limb is negligence for which the medical man is liable for injury resulting therefrom.

In a Newfoundland case³⁵¹ a patient lost a great volume of blood after a dental extraction. When he finally sought medical assistance he was near collapse but the dentist was not held liable for the failure to warn him of the limits of normal blood loss. The trial judge said, "any adult of sound mind must be expected to know and appreciate the effect of too much loss of blood." Regarding the warning a doctor should give about symptoms, he said:³⁵²

Now, I am prepared to believe that in some kinds of cases, particularly in this domain of medicine and surgery, the failure by a doctor or surgeon to warn a patient as to the meaning of certain symptoms, the significance of which might not be apparent to a layman, might properly expose the practitioner to a charge of negligence. The physician cannot always be in constant attendance upon his patient, who may have to be left to his own devices; and if the former knows of some specific danger and the possibility of its occurring, it may well be part of his duty to his patient to advise him of the proper action in such emergency. As an example that occurs to me, a bandage or plaster cast may stop the circulation of the blood; if this occurs the patient may think it perfectly normal and do nothing about it, while if given the proper instruction beforehand he could at once inform the doctor or hospital. [emphasis supplied]

Thus, if the symptoms to be watched for are of a readily observable kind, or commonly known such as in the previous case, there may be little or no duty for the practitioner to warn the patient, since a reasonable person in the position of the patient would become concerned with such an

351. Murrin v. Janes supra n. 218.

352. Id. at 405.

event. If, on the other hand, the warning signs that may occur are not pronounced, appear unrelated to the illness being treated, or may be unfamiliar to the patient, there may be a heavier burden on the practitioner to warn his patient.

For example, a doctor was held liable when he failed to warn a patient following knee surgery that the drug he prescribed for her was an anti-coagulant which had the dangerous possible side effect of causing haemorrhage.³⁵³

Similarly, a practitioner must warn a patient of the possible results that may be occasioned by a change in treatment. In a British Columbia case³⁵⁴ the patient had diabetes and had taken insulin for eleven years. He went to the doctor to see if he could receive a special diet which would enable him to reduce and possibly to eliminate the dosage of insulin. The doctor put him on a special diet and reduced the insulin substantially. A diabetes specialist, called by the patient at trial, said that this was a risky procedure because the results are difficult to predict. Within a week the patient was ill in a condition of pre-coma, and went to hospital where his condition improved. At the trial there was a dispute as to the instruction the doctor had given the patient. The doctor blamed the patient for not following instructions. The trial judge found that the only warning given was that the patient might expect a reaction and might be away from work for several days. The court found that the doctor had not met the standard of care in carrying out his duty

353. Crichton v. Hastings *supra* n. 14.

354. Marshall v. Rodgers [1943] 2 W.W.R. 545 (B.C.C.A.).

to instruct the patient because the treatment was dangerous and the doctor did not monitor the patient as carefully as he should have.³⁵⁵

There might be cases in which certain duties might be properly delegated by an attending physician to others...but in a case such as this, where admittedly a dangerous remedy was being tried, it would seem to me that the appellant was negligent in delegating to the patient himself the duty of deciding what his real condition was from time to time from what might be called only his subjective symptoms without having daily tests made.

Had the doctor in this case given adequate or reasonable instructions and warnings which the patient had not followed, then the patient might have lost his case or been held contributorily negligent.³⁵⁶

4. Conclusion

The principles of negligence law have been discussed in some detail and with reference to the cases that have come before our courts, in the hope that they will thus be more easily understood. Of all areas of private law, negligence is the most flexible and sensitive to necessary change. Because it is continually developing and being applied to novel purposes, there tends to be some inconsistency in terminology and analysis.³⁵⁷ This troubles many in both the legal and medical professions but it should be remembered that this is only a symptom of its adaptability.

355. Id. at 555.

356. Crossman v. Stewart *supra* n. 83.

357. For an example of this with regard to duty see Smith, supra n. 3.

lity, which in turn justifies an optimistic expectation of the continued utility of tort law for adjudicating disputes between doctors and patients and, more importantly, for contributing to positive changes in the doctor-patient relationship.

A doctor must care for his patients according to his duties and standards discussed in this chapter; but he is neither guarantor nor insurer of good results:³⁵⁸

It is easy to be wise after the event and to condemn as negligence that which was only a misadventure. We ought always to be on our guard against it, especially in cases against hospitals and doctors. Medical science has conferred great benefits on mankind but these benefits are attended by considerable risks. Every surgical operation is attended by risks. We cannot take the benefits without taking the risks. Every advance in technique is also attended by risks. Doctors, like the rest of us, have to learn by experience; and experience often teaches in a hard way.

358. Roe v. Minister of Health *supra* n. 78 at 83 *per* Denning L.J.

CHAPTER VI

DEFENCES TO AN ACTION IN NEGLIGENCE

The preceding chapter studied the negligence action primarily from the point of view of the plaintiff. Its concern was to describe what the plaintiff in a negligence action against a doctor or hospital¹ must prove. This chapter deals with the action from the defendant's point of view, and describes the various defences available to a doctor or hospital in a negligence action.

The defences can be roughly divided into two groups, informally labelled for the purpose of this discussion as "passive" and "active" defences. A plaintiff in a negligence action must succeed in proving all the elements discussed in Chapter V; his failure to do so will result in his losing the case. By the term "passive defence" is meant a defence which relies upon the plaintiff's failure to prove one of the elements of his case. This can occur in two ways.

First, a plaintiff who fails to show the existence of duty,² breach of the standard of care, injury or causation may face at the end of his case the defendant's application for a "non-suit" which is a request that the action be stopped then and there because the plaintiff has failed to make out a prima facie case, that is, a case in which all

1. The position of the hospital is discussed in more detail infra Chapter 10.

2. This is very rare in medical negligence cases.

the required elements appear to be supported by some evidence. If the defendant's application is successful the action will be dismissed and no defence will be required. This rarely occurs, however, because cases of such little substance are rarely taken to trial.

Second, which is the more usual instance, the defendant may attack the essentials of the plaintiff's claim by the introduction of evidence of his own and by discrediting of the plaintiff's evidence through cross-examination and other adversarial techniques.³ The passive defences need not be discussed any further; they are easily implied from an understanding of the elements of the negligence action, discussed in Chapter V.

Frequently, however, a defendant will find it necessary to take advantage of what we have for convenience called the "active" defences. These are the subject of this chapter and involve proof by the doctor that:

- (a) he followed the approved practice and was therefore not negligent,
- (b) he was at most guilty of an error of judgment from which no liability flows,
- (c) the patient was wholly or partially the author of his own misfortune, or
- (d) the action is technically barred from a hearing on its merits because the limitation period has lapsed.

3. Described infra Chapter 8.

1. Approved Practice⁴

This defence is responsive to the allegation that the defendant has breached the standard of care. It is an attempt by the defendant to prove that the practice or procedure he followed was generally approved and employed by his colleagues at the time in issue and therefore ought not to be regarded as negligence. In medical cases the defence is very old⁵ but is still surrounded by considerable uncertainty. Reference to what other members of a profession or business do by custom is not uncommon in negligence actions generally, but such evidence is sometimes relied upon to a greater degree in medical negligence cases.⁶

The treatment which is in issue is compared to the approved practice at the time and in the circumstances in which the treatment occurred,⁷ and therefore what was approved practice yesterday may be obsolete today. The doctor who fails to keep pace with advances in medical science may discover that his tried and true but outdated tools or techniques are found wanting.⁸ On the other hand, a doctor who acts according to what was approved practice at the time of the alleged negligence will not be viewed in the light of what has developed in the

4. Also in use are the terms custom and common practice.

5. In Jackson v. Hyde (1869) 28 U.C.Q.B. 294 (C.A.) a new trial was granted.

6. Linden, Canadian Tort Law 141 (1977).

7. Whiteford v. Hunter [1950] W.N. 553 (H.L.).

8. McCormick v. Marcotte [1972] S.C.R. 18; St-Hilaire v. S. [1966] C.S. 249 (Que. S.C.).

interim between the time of the treatment and the time of the trial. In a recent case⁹ in which the patient was rendered a quadriplegic during the taking of a subclavian angiogram, the defendant radiologist's defence of approved practice was successful. While the cause of the quadriplegia, costocervical leakage into the spinal cord, was recognized in the medical literature at the time of trial, it was an unknown hazard at the time of treatment, and therefore while failure to take precautions against it today would be negligence, it was not so in 1973.¹⁰

The defendant bears the onus of proving that his conduct conformed to the approved practice at the time and the role of experts can be crucial in helping him to establish the defence. A patient who required an amputation because of undiagnosed gas gangrene¹¹ called a surgeon who testified that the proper practice in compound fracture cases was to debride the wound and, if circulatory problems arose, to split the cast. The evidence of the defendant's experts, one of whom was an orthopedic surgeon, was that they would have done just what the defendant did, and the action was dismissed. The courts do not always follow the experts, however. The Supreme Court of Canada found a psychiatrist liable for the suicide of his patient in the face of testimony from all the experts called that they would have done exactly

9. McLean v. Weir (1977) 3 C.C.L.T. 87 (B.C.S.C.). See also Roe v. Minister of Health [1954] 2 Q.B. 66 (C.A.).

10. McLean v. Weir *id.* at 100.

11. Challand v. Bell (1959) 18 D.L.R. (2d) 150 (Alta. S.C.). See also Bennett v. C. (1908) 7 W.L.R. 740 (Man. S.C.).

as the defendant had done.¹² A defendant will also have difficulty proving his case if the practice on which he is relying is limited to, for example, one hospital, if his defence is supported only by the evidence of a non-expert, or if no supporting witness is called at all.¹³

Sometimes there is no universal practice.¹⁴ If the common practice is divided but the defendant is among the majority, his position is substantially the same as if no split existed.¹⁵ When he is among the minority, there is authority that the question is whether the practice is followed by "at least a respectable minority of competent practitioners in the same field."¹⁶ This approach seems reasonable as it encourages the adoption of new beneficial medical procedures yet guards against the use of novel and untested techniques.

Evidence that the defendant's conduct either conformed to or departed from approved practice is clearly significant.¹⁷ While a departure from the approved practice is a strong indication of the failure to meet a reasonable standard of care (although not

12. Villemure v. Turcot [1973] S.C.R. 716; reversing [1970] C.A. 538 (Que.).

13. Anderson v. Chasney [1949] 4 D.L.R. 71 at 82; affirmed [1950] 4 D.L.R. 223 (S.C.C.).

14. Karderas v. Clow (1973) 32 D.L.R. (3d) 303 (Ont. H.C.).

15. Bouillon v. Poire (1937) 63 Que. K.B. 1 (C.A.). See also Hunter v. Hanley [1955] S.L.T. 213 (1st Div.). Both cases deal with dentists and broken needles.

16. Meredith, Malpractice Liability of Doctors and Hospitals 64 (1957) citing two U.S. cases as authority. See also Bolan v. Friern Hospital [1957] 2 All E.R. 118 (Q.B.).

17. Gent v. Wilson [1956] O.R. 257 (C.A.).

conclusive)¹⁸ the effect of the defendant's conformity with approved practice is not clear. It may be either a conclusive defence or simply another factor for the court to consider. There is presently no strong statement in Canadian jurisprudence as to which of these is the proper view.¹⁹

The cases fall into three categories: those that seem to hold that compliance with the approved practice is conclusive of no negligence, those that say it is only prima facie evidence of no negligence, and those which are open to either interpretation or are simply unclear.

The seminal case for those cases which hold that compliance with approved practice is a complete defence is McDaniel v. Vancouver Gen. Hospital.²⁰ The patient, who went into hospital with diphtheria and was placed in a ward near seven smallpox patients, contracted smallpox, along with eight others. The trial judge and the Court of Appeal found the hospital to be negligent by putting her there where the same nurses were attending all patients, even though the expert evidence was that the defendant's practice was a general one in Canada and the United States. On a direct appeal to the privy Counsel in England, the earlier decisions were reversed: Lord Alness said:²¹

A defendant charged with negligence can clear his feet if he shows that he acted in accord with general and approved practice.

18. Fleming, The Law of Torts 118 (5th ed. 1977); see Adderley v. Bremner (1967) 67 D.L.R. (2d) 274 (Ont. H.C.).

19. Weiler, Groping Towards A Canadian Tort Law: The Role of the Supreme Court of Canada (1971) 21 U.T.L.J. 267.

20. McDaniel v. Vancouver Gen. Hospital [1934] 4 D.L.R. 593; reversing [1934] 1 D.L.R. 557 (P.C.).

21. Id. at 597.

The case, and these words, have been cited with approval in later Canadian and even English²² cases, but close scrutiny of the case shows that it has grave flaws. First, Lord Alness cited no authority for the above quoted statement of the law. Second, he uttered earlier the startling proposition that the plaintiff in the case had the onus of proving negligence beyond a reasonable doubt. This was a clear error, as that burden of proof exists only in criminal cases. Third, it appears that the defendant's evidence went virtually unchallenged. The patient called only her family doctor while the defendant had a battery of six experts who affirmed as the general practice the course of action which the defendant had followed. A court faced with cogent uncontradicted evidence has little choice but to follow it and, in such circumstances, even a court which regarded the proof of approved practice as only a factor would likely find for the defendant.

A dearth of evidence by the plaintiff marks many cases following the McDaniel rationale. Uncontradicted expert evidence that the patient was treated according to approved practice led to a finding of no liability for a British Columbia hospital²³ when a patient suffering from multiple sclerosis fell out of a bed without side rails. In a similar fact situation an elderly lady awaiting a cataract operation was injured in a fall from a hospital bed, but the hospital

22. Marshall v. Lindsey County Council [1935] 1 K.B. 516; affirmed [1937] A.C. 97 (H.L.).

23. McKay v. Royal Inland Hospital (1964) 48 D.L.R. (2d) 665 (B.C.S.C.); see also Cahoon v. Edmonton Hospital Bd. (1957) 23 W.W.R. 131 (Alta. S.C.).

was held not liable.²⁴ The defendant's evidence that guard rails were not required was not rebutted. Finally, a case²⁵ where the defendant clearly established that he had followed approved practice in treating a psychiatric patient who committed suicide, the plaintiff had no contrary evidence, and the doctor and hospital were held not negligent.²⁶ There is a lesson here for counsel in future cases, in connection with the plaintiff's privilege to adduce rebuttal evidence after a doctor has introduced evidence of approved practice.²⁷

The plaintiff had adequate opportunity and was virtually invited to call medical evidence in rebuttal. For the plaintiff the most advantageous of all times in this trial for medical evidence was in rebuttal, after all the defence's experts had been heard. No rebuttal medical evidence was offered. Instead the court was invited, urged, to speculate against the unanimous evidence of exceptionally well qualified experts to bring in a finding contrary to their opinions.

Thus, from McDaniel v. Vancouver Gen. Hospital has come the view that the effect of proof of approved practice defence is to establish a conclusive defence for the doctor or hospital. However, McDaniel itself has much to raise doubt as to its authority, and the cases purporting to follow it can be explained as cases of uncontradicted expert evidence, where the plaintiff simply failed to discharge his onus of

24. Florence v. Les Soeurs de Misericorde (1962) 39 W.W.R. 201 (Man. C.A.).

25. Stadel v. Albertson [1954] 2 D.L.R. 328 (Sask. C.A.); see also Karderas v. Clow *supra* n. 14.

26. All of these cases cited and applied McDaniel v. Vancouver Gen. Hospital *supra* n. 20.

27. McLean v. Weir *supra* n. 9 at 101.

proving negligence by a preponderance of evidence.

On the other hand, there is a respectable body of law supporting the proposition that compliance with approved practice is only prima facie evidence of no negligence. The authorities include more recent cases and a Supreme Court of Canada decision.²⁸

In Anderson v. Chasney,²⁹ a case heard by the Supreme Court of Canada, a surgeon who performed a tonsilloadenoidectomy on a child was told by the anaesthetist, after the operation, that all the sponges had not been removed. The surgeon checked and found no sponges, but the child later died by suffocating on one. The defendant testified that it was not his practice to use sponges with strings nor to have a nurse count sponges, and there was evidence that in not doing so he followed the practice in his hospital. But both methods were available to him and were used by some surgeons in other hospitals. The Supreme Court of Canada approved the conclusion of the Manitoba Court of Appeal³⁰ which was that expert evidence as to approved practice is not conclusive, especially where the conduct being questioned is not technical but relates to taking precautions. The courts decided that as far as non-technical matters are concerned, an ordinary person is competent to determine what is a safe practice, and held the defendant negligent.

28. See also Meredith, *supra* n. 16 at 64.

29. Supra n. 13.

30. [1949] 4 D.L.R. 71.

In Crits v. Sylvester,³¹ another tonsillectomy case, the patient became cyanotic during the operation and the anaesthetist took emergency measures to correct the situation. After doing so he left a valve slightly open and some oxygen escaped which exploded, causing injury to the patient. The main issue was whether the anaesthetist was negligent by leaving the oxygen valve partly open, and the doctor's primary defence was that he had followed approved practice. This the court³² doubted, and added:³³

Even if it had been established that what was done by the anaesthetist was in accordance with "standard practice", such evidence is not necessarily to be taken as conclusive on an issue of negligence, particularly where the so-called standard practice related to something which was not essentially conduct requiring special medical skill and training either for its performance or a proper understanding of it. This was the view of the Court of Appeal of Manitoba in Anderson v. Chasney....If it was standard practice, it was not a safe practice and should not have been followed.
[emphasis supplied]

The anaesthetist's appeal to the Supreme Court of Canada³⁴ was dismissed. Regarding the main basis for liability the court said that there was no evidence that what the defendant did was within the approved practice. However, on another ground of alleged negligence, the doctor had complied with the approved practice, and the court

31. [1955] 3 D.L.R. 181 (Ont. H.C.).

32. (1956) 1 D.L.R. (2d) 502 (Ont. C.A.).

33. Id. at 514.

34. [1956] S.C.R. 991.

said:³⁵

But the anaesthetist's conduct in this respect has been approved by other medical witnesses, and it would be dangerous for a Court to attempt in such a matter to proscribe a step approved by the general experience of technicians and no shown to be clearly unnecessary or unduly hazardous.

Thus, while the Supreme Court of Canada indicated that it would be dangerous to reject approved practice, it did not say that the court had no such power;³⁶ in fact, it implied that a court was to exercise the power if the practice was "clearly unnecessary or unduly hazardous."

These two cases placed restrictions on the court's discretion to hold a defendant liable in the face of approved practice by limiting it to non-technical or precautionary matters. They have been ignored in a number of more recent cases.

Two of these cases are from the Manitoba Court of Appeal. In the earlier one³⁷ a chiropractor by his manipulations caused serious injury to a patient who was suffering from an extruded vertebral disc. The defendant called expert evidence that in doing so he had been following approved practice. But his own testimony was found to be "conclusive as to the unwisdom of the practice he followed,"³⁸ and he was found liable by both courts. The Court of Appeal affirmed Anderson

35. Id. at 992.

36. See also Johnston v. Wellesley Hospital (1970) 17 D.L.R. (3d) 139 at 148 (Ont. H.C.).

37. Penner v. Theobald (1962) 38 W.W.R. 397; affirmed 40 W.W.R. 216 (Man. C.A.).

38. (1962) 40 W.W.R. 216 at 229.

v. Chasney³⁹ and said:⁴⁰

Moreover, while it is true that in the great majority of alleged malpractice cases a charge of negligence can be met by evidence to the effect that what was done was in accordance with general and approved practice, nevertheless it is the courts and not the particular profession concerned which decide whether negligence is established in a particular case. [emphasis supplied]

In the later case⁴¹ an orthopedic surgeon was found to have followed approved practice in surgery and in post-operative treatment but the patient died. The Court of Appeal affirmed the trial judge who had said:⁴²

It is very easy, after the happening of the event of misadventure, to condemn Dr. Ahsan for being negligent because he left the patient in the recovery room in the charge of regular hospital staff before she actually woke up, and proceeded to attend to his other duties in another hospital. In truth, however, this same procedure followed by Dr. Ahsan is practised by most of the orthopaedic surgeons in this area and their patients suffer no ill effects. I would like to point out however that even had Dr. Ahsan followed accepted practice of the profession, he could not escape liability if such practice did not meet the legal requirement of care for the patient. [emphasis supplied]

The Supreme Court of Canada in Villemure v. Turcot⁴³ held a psychiatrist and a hospital liable for the death of a patient known to

39. Supra n. 13.

40. (1962) 40 W.W.R. 216 at 228-229.

41. Chubey v. Ahsan [1975] 1 W.W.R. 120; affirmed [1976] 3 W.W.R. 367 (Man. C.A.).

42. [1975] 1 W.W.R. 120 at 129.

43. [1973] S.C.R. 716.

be suicidal who fell from a hospital window.⁴⁴ This was done in the face of the unanimous expert evidence that the defendants had followed approved practice in caring for the patient. Two Justices who dissented said the court must be guided by the approved practice.

Unfortunately the majority did not take this opportunity to clarify the law but simply adopted the reasons of a dissenting Justice of the Court of Appeal of Quebec who had in turn adopted the trial judge's reasons. At trial, two experts said that they would have done exactly what the defendant doctor had done, to which the trial judge replied that had they done so they too would have been negligent.

In view of this decision of the Supreme Court of Canada it is difficult to accept the dicta of a British Columbia Supreme Court⁴⁵ which referred to McDaniel but did not consider Villemure. The trial judge said:⁴⁶

The court has no status whatsoever to come to a medical conclusion contrary to unanimous medical evidence before it even if it wanted to, which is not the situation in this case. If the medical evidence is equivocal, the court may elect which of the theories advanced it accepts. If only two medical theories are advanced, the court may elect between the two or reject them both; it cannot adopt a third theory of its own, no matter how plausible such might be to the court.

To summarize, a fair synopsis of the present law as to the effect of the approved practice defence is as follows. The defence of

44. Note the case of University Hospital Bd. v. Lepine [1966] S.C.R. 561 was distinguished as being one where there was no warning of the patient's suicidal tendencies.

45. McLean v. Weir *supra* n. 9.

46. Id. at 101.

approved practice raises a prima facie case that the standard of care has been met. When the defendant is a hospital which has followed an approved practice the defence is stronger and may even be conclusive. Whatever the effect, the court has the power to find compliance with approved practice to be negligence. A court is more likely to exercise this power in regard to non-technical matters, or safety precautions where the layman can appreciate the risks to a patient. When defendants have been exonerated because of compliance with approved practice those practices have been found to meet the standard of care or have not been shown to be substandard by expert evidence presented by the plaintiff. Compliance with approved practice may be negligence but failure to comply is not necessarily negligence.⁴⁷

Lack of clarity in the law and in some decisions makes it difficult to fit some of the cases into these conclusions. Two important cases serve as good examples. Professor Weiler⁴⁸ has characterized Wilson v. Swanson⁴⁹ as a case where the defence of approved practice was conclusive. Yet the defendant, who had onus of proving the defence, called no evidence at all, and relied on the plaintiff's failure to establish a prima facia case of negligence. Indeed, there is no patent discussion of the defence at any level but in the result it would seem that the decision was that the defendant had followed approved practice; at least he was held to have met the standard of care.

47. Hunter v. Hanley supra n. 15. See Linden, The Negligent Doctor (1973) 11 Osgoode Hall L.J. 31 at 34.

48. Supra n.19 at 335.

49. [1956] 5 D.L.R. (2d) 113 (S.C.C.).

In another Supreme Court of Canada case, Ostrowski v. Lotto,⁵⁰ the evidence was balanced and the doctor was found to be negligent at trial, although he "may well have been consistent with accepted standards",⁵¹ but not negligent in the higher courts. Approved practice was referred to directly by the Court of Appeal⁵² who, ignoring Canadian jurisprudence, chose to adopt law from an English case which held that compliance with approved practice is conclusive of no negligence. The Supreme Court of Canada adopted the Court of Appeal's reasons. Both cases seem to follow the McDaniel rationale but their authority seems weak, given the apparent insufficiency of defence evidence in Wilson and failure to deal with Canadian jurisprudence in Ostrowski.

Professor Weiler⁵³ has called for a reconciliation of the divergent decisions. It is to be hoped that the Supreme Court of Canada, will at the first opportunity, heed his plea.

If the defence is conclusive, the outcome is determined solely by the expert evidence; the judge plays only a minor role in the decision. However, if the effect of compliance with approved practice is only to raise a prima facie case of no negligence, as is the case

50. (1972) 31 D.L.R. (3d) 715.

51. These are the words of the trial judge (1968) 2 D.L.R. (3d) 440 at 455 (Ont. H.C.).

52. (1970) 15 D.L.R. (3d) 402 at 412 adopting Bolam v. Friern supra n. 16.

53. Supra n. 19.

with respect to other professions,⁵⁴ then the judge maintains an active role in determining the outcome, which seems to be consistent with the view often expressed that it is the court which sets the standard, not the profession.⁵⁵

Reflection on the policy of giving any effect at all to the evidence of approved practice would be helpful to the resolution of the issue.⁵⁶ A judge has no expertise in medical matters. He is taught by the experts who give evidence and must by listening and asking questions learn enough to review the defendant's exercise of his professional skill and judgment. The process is no different when the defendant is an engineer, a lawyer, or any other professional. The approved practice is likely what the professional learned and developed competence in doing.⁵⁷ It is what his colleagues expect him to do and may be all he knows how to do. When a court strikes it down as inadequate or sub-standard, the profession may feel that it has suffered a severe blow.⁵⁸ On the other hand, no person or profession is to be above the law. Neither engineer nor artisan is free to set the

54. Dziwenka v. R. [1971] 1 W.W.R. 195 at 205 (Alta. C.A.).

55. Supra Chapter 5.

56. Linden, supra n. 6 at 136.

57. Morris, Custom and Negligence (1942) 42 Colum. L. Rev. 1147 at 1148.

58. See Helling v. Carey (1974) 519 P. 2d 981 (Wash. S.C.) where an ophthalmologist was found negligent in failing to administer a simple test to diagnose glaucoma, despite the fact that in failing to do so he had complied with the approved practice. For a comment see Mann (1975) 28 Vand. L. Rev. 441. See also Pearson, The Role of Custom in Medical Malpractice Cases (1976) 51 Ind. L.J. 528.

standard of care the public requires,⁵⁹ nor should the medical profession. Inertia is a disease that knows no professional borders. The courts on behalf of the public have a critical role to play in reviewing, monitoring, and precipitating change in professional standards. Of course, there must be a balancing of professional and public interests; holding compliance with approved practice to be negligence may be the only route to move some members of a profession to a new, better course,⁶⁰ yet may also impede medical progress.⁶¹ The courts are the appropriate organ for the adjustment of this balance, and should not abdicate their responsibility to adjudicate upon the negligence in any profession.

2. Error of Judgment

A doctor is not liable for an honest error of judgment provided he acts after a careful examination in what he believes to be the patient's best interests.⁶² A doctor can give no guarantee of success, nor insure a cure, so a diagnosis may be inaccurate or treatment may be improper and an injured patient may go uncompensated. Negligence cannot be assumed simply on the basis of the consequences of medical treatment to a patient. The conduct of a doctor is not to be

59. Penner v. Theobald (1962) 35 D.L.R. (2d) 700 at 712 (Man. C.A.).

60. Anderson v. Chasney *supra* n. 13; Villemure v. Turcot *supra* n. 43.

61. Cryderman v. Ringrose [1977] 3 W.W.R. 109; affirmed [1978] 3 W.W.R. 481 (Alta. C.A.).

62. Meredith, *supra* n. 16 at 63; Linden, *supra* n. 47 at 39.

measured by the result, for the practice of medicine is an art as well as a science; a great deal of medical treatment depends on the exercise of judgment. So long as in exercising it a doctor meets the standard of care required of him he will not be liable.

Error of judgment is a defence in which the doctor admits he made an error, but denies that he is negligent because he possessed and exercised the skill, knowledge and judgment of the average of his special group when considering the patient's case.⁶³ There are many Canadian cases in which the defence has been accepted and it is accordingly well defined.

The case most often referred to in defining error of judgment is Wilson v. Swanson⁶⁴ where the surgeon in the course of an operation had to decide whether to proceed with more radical surgery if the conditions he found indicated a malignant growth rather than a benign one. He made an error of judgment in deciding it was malignant and removed a large portion of the stomach, pancreas and spleen. The court said⁶⁵

An error in judgment has long been distinguished from an act of unskillfulness or carelessness or due to lack of knowledge. Although universally accepted procedures must be observed, they furnish little or no assistance in resolving such a predicament as faced the surgeon here. In such a situation a decision must be made without delay based on limited known and unknown factors; and the honest and intelligent exercise of judgment has long been recognized as satisfying the professional obligation. [emphasis supplied]

63. Challand v. Bell *supra* n. 11 at 154.

64. Supra n. 49.

65. Id. at 120.

This court and others in Canada have adopted a statement of the law from an American case:⁶⁶

He is not to be judged by the result, nor is he to be held liable for an error of judgment. His negligence is to be determined by reference to the pertinent fact existing at the time of his examination and treatment, of which he knew, or in the exercise of due care, should have known. It may consist in a failure to apply the proper remedy upon a correct determination of existing physical conditions, or it may precede that and result from a failure properly to inform himself of these conditions. If the latter, then it must appear that he had a reasonable opportunity for examination and that the true physical conditions were so apparent that they could have been ascertained by the exercise of the required degree of care and skill. For, if a determination of these physical facts resolves itself in a question of judgment merely, he cannot be held liable for his error.

Johnston v. Wellesley Hospital⁶⁷ is an example of harmful treatment being held to be only an error of judgment. The patient suffered from acne and the doctor, a dermatologist, decided to treat it with a mixture of frozen carbon dioxide and acetone set on the face for fifteen seconds. The time turned out to be too long and the patient suffered permanent scarring. The court held this to be "an error of judgment, but no more."⁶⁸

Failure to correctly diagnose the patient's condition has also been held to be an error of judgment in a number of cases.⁶⁹ In 1953, a rural general practitioner missed a diagnosis of gas gangrene which

66. Rann v. Twitchell (1909) 82 Vt. 79 at 84, 71 A. 1045 at 1046 (Vt. S.C.).

67. (1970) 17 D.L.R. (3d) 139 (Ont. H.C.).

68. Id. at 152.

69. See supra Chapter 5.

required the amputation of part of the patient's arm⁷⁰ and in 1960 a small-town general practitioner failed to diagnose a rare throat condition affecting respiration.⁷¹ In 1962 in Saskatchewan a general practitioner misdiagnosed as appendicular colic what was an acute attack of appendicitis,⁷² and in 1964 in Alberta a general practitioner diagnosed a family to be suffering from influenza when in fact it was carbon monoxide poisoning, and three children died.⁷³ All doctors were held to be guilty of an error of judgment, or a mistaken but honest opinion.

Finally, in an unusual case, it was held that a hospital was not liable because a nurse failed to call an orderly to assist in raising a bed. The failure were merely an error in judgment and thus the hospital was not liable for injuries suffered by the patient's husband when he assisted in lifting the bed.⁷⁴

By contrast, it was not an error in judgment to fail "to carry out a reasonable, adequate and proper post-operative observation of [a patient's] legs to watch for signs of circulatory impairment."⁷⁵ In discussing the authorities on the defence the trial judge set out the

70. Challand v. Bell *supra* n. 11.

71. Tiesmaki v. Wilson [1975] 6 W.W.R. 639 (Alta. C.A.).

72. Wilson v. Stark (1967) 61 W.W.R. 705 (Sask. Q.B.).

73. Ostash v. Sonnenberg (1968) 63 W.W.R. 257 (Alta. C.A.).

74. Elverson v. Doctor's Hospital (1976) 4 O.R. (2d) 749 (Ont. C.A.).

75. Badger v. Surkan (1970) 16 D.L.R. (3d) 146 at 162; affirmed [1973] 1 W.W.R. 302 (Sask. C.A.).

following explanation of the law.⁷⁶

The law, as exemplified by the above and other authorities, in my opinion, clearly protects a doctor from liability to his patient for damages in cases where with respect to medical technical matters, the doctor honestly and intelligently applied his mind to the problem presenting itself and arrived at a conclusion or judgment upon which he acted, which conclusion or judgment subsequently proved to be wrong. He made an honest but wrong decision as to what course to take in the prevailing circumstances.

Similarly, the defence of error of judgment pleaded by a doctor who operated to remove a cyst was not successful. The doctor was found to be negligent and the court said:⁷⁷

In the face of the medical evidence of the danger inherent in removing an infected cyst in that particular area because of the close proximity of the spinal accessory nerve, it seems to me that more than a mere error in judgment was involved; that the doctor should have been aware of these dangers and deferred surgery until the infection had been treated.

Unlike the defence of approved practice, the effect of the defence of error of judgment is certain - there is no liability. But it is more difficult to predict when this defence has been established, and the credibility and sincerity of the doctor as well as the strength of his expert evidence are obviously important. As Meredith⁷⁸ pointed out, the strength of this defence is often overlooked by plaintiffs.

76. Id. at 162.

77. Fizer v. Keys [1974] 2 W.W.R. 14 at 25 (Alta. S.C.).

78. Meredith, supra n. 16 at 63.

3. Contributory Negligence of the Patient

A patient has certain duties toward the doctor and to himself. In carrying out these duties he is expected to meet the standard of care of a reasonable patient. If he does not and the breach of this standard is the factual and proximate cause of his injuries he is contributorily negligent,⁷⁹ and his compensation will be reduced accordingly.⁸⁰ Of course, if his injury is due exclusively to his own negligence his action will be dismissed.⁸¹

The effect of such a finding at one time precluded any recovery by the patient in Canada but all provinces now have legislation directing a court to apportion damages in proportion to the degree of fault found against the respective parties.⁸² The legislation also provides that if it is not practicable to determine respective degrees of fault or

79. For a discussion of these see supra Chapter 5.

80. Linden, supra n. 6 at 403.

81. Meredith, supra n. 16 at 88.

82. Contributory Negligence Act, R.S.A. 1970, c. 65 [am. 1975 (2), c. 56, s. 164] and Tort-Feasors Act, R.S.A. 1970, c. 365; Contributory Negligence Act, R.S.B.C. 1960, c. 74 [am. 1969, c. 35, s. 4; 1970, c. 9]; Tortfeasors and Contributory Negligence Act, R.S.M. 1970, c. T-90 [am. 1973, c. 13]; Contributory Negligence Act, R.S.N.B. 1973, c. C-19 and Tortfeasors Act, R.S.N.B. 1973, c. T-8; Contributory Negligence Act, R.S. Nfld. 1970, c. 61; Contributory Negligence Act, R.S.N.S. 1967, c. 54 and Tortfeasors Act, R.S.N.S. 1967, c. 307; Negligence Act, R.S.O. 1970, c. 296 [am. 1975, c. 41, s. 7; 1977, c. 59]; Contributory Negligence Act, R.S.P.E.I. 1974, c. C-19; Contributory Negligence Act, R.S.S. 1965, c. 91. Note that in Quebec the notion of partage de responsabilité has long been admitted: Hôpital Notre Dame de l'Espérance v. Laurent [1978] 1 S.C.R. 605. See Kouri, The Patient's Duty to Co-operate (1972) 3 Rev. D.U.S. 44 at 57.

negligence the parties are deemed to be equally at fault. Thus, the defence of contributory negligence is no longer a complete one in Canada nor in England although it remains so in some of the United States.⁸³ As with all defences, the onus of proving it is on the defendant doctor or hospital.⁸⁴

A simple example of how apportionment legislation works follows. Assume a doctor is found to be negligent in his treatment of a patient, who is found to be contributorily negligent for failing to follow the doctor's instructions. If the judge assessed the patient's damages at \$10,000 and apportioned liability as 60% to the doctor and 40% to the plaintiff, the result would be that the patient would recover \$6,000.

While contributory negligence has been discussed in a handful of Canadian cases there is only one from British Columbia and one from Quebec where it seems to have been applied. Theoretically the law and practice in a medical negligence case should be the same as in any other negligence case and the decision to find contributory negligence has been "quite frequent"⁸⁵ in the ordinary negligence action. One explanation for its rare application in medical negligence cases might be that the seemingly unequal position of the parties, in that the plaintiff patient may have been ill, submissive, or incapable of acting in his own best interests, has led the courts to set the standard of care that patients must meet for their own care at an unreasonably low

83. See Louisell and Williams, Medical Malpractice, Matthew Bender, New York, 1977 at 246.

84. Town v. Archer (1902) 4 O.L.R. 383 (K.B.).

85. Klar, Contributory Negligence and Contribution Between Tortfeasors in Studies in Canadian Tort Law 146 (2d ed. Klar 1977).

level. As patients strive for a more equal role in their medical care and for taking aggressive steps in their own treatment, it is predictable and no doubt just that there will be more patients found to be contributorily negligent with a consequential reduction in the compensation that they will receive.

In the recent British Columbia case⁸⁶ a patient was held to be two-thirds to blame for the blindness she suffered and her doctor, a dermatologist, one-third to blame. (Thus she would get \$26,666 of the \$80,000 assessed as damages). She had consulted the dermatologist for a facial skin disorder and he prescribed a drug known as chloroquine or "Aralen" which she took for approximately 6 months under prescription. Because she was a medical receptionist she was able to obtain the drug from a drug salesman at one-half the price and without a prescription and for seven months she took the drug on this basis. At that time the dermatologist who had been alerted to the possible serious side effects of the drug to vision had all patients whom he had treated with it see an ophthalmologist. Unfortunately, he did not read carefully enough the resulting report on the plaintiff because it would have alerted him to the patient's unorthodox practice. Thereafter for two more years the patient obtained the drug from the salesman and when this man retired she went back to the defendant and was prescribed the drug for at least a further eight months. The trial judge found that at no time was the patient warned of the danger of prolonged use of the drug but also that the defendant did not have actual knowledge of her continuous

86. Crossman v. Stewart (1977) 5 C.C.L.T. 45 (B.C.S.C.).

use of it either. The evidence indicated that her eyes would not have been damaged had her consumption been limited to the prescriptions.

The patient's negligence was found to lie in obtaining prescription drugs from an unorthodox source, using them on a prolonged basis, and not consulting her doctor. She had failed to meet the standard expected of a reasonable patient and was the major cause of her own injury. The doctor's negligence was based on his failure to carefully peruse the ophthalmologist's report and his failure to discern from "corneal changes" in that report the probability of recent consumption of the drug. This was obviously a clear case for the application of the contributory negligence rules. In fact, it is even arguable that like the dental patient who nearly bled to death before obtaining medical assistance⁸⁷ this patient was the sole cause of her injury. The standard of care expected of the reasonable patient is tied to the degree of knowledge with respect to medical matters possessed by the layman. Just as the reasonable person is taken to know the loss of a large volume of blood will seriously endanger his health, he ought also to be attributed with the knowledge that obtaining and consuming prescription drugs without medical supervision is risky. However, the fact remains that the plaintiff in this case was given no warning as to the danger of this particular drug and in fact, after what she would believe was a satisfactory ophthalmological examination, may have had reason to believe that the drug was safe.

87. Murrin v. Janes [1949] 4 D.L.R. 403 (Nfld. S.C.).

In the Quebec case,⁸⁸ the evidence of the doctor and patient was in substantial conflict but the higher courts were not prepared to disturb the trial judge's holding that the patient was contributorily negligent. The doctor was held negligent for failing to diagnose a fracture of the head of the femur but the patient did not get further medical treatment for over three months and her claim was reduced by one-quarter. Unlike the patient in the British Columbia case who was active in her own treatment, this patient was passive: she failed to seek treatment. The difference in conduct is reflected in the amount by which each patient's compensation was reduced.

The defence was pursued by a hospital without success in another Canadian case, Bernier v. Sisters of Service.⁸⁹ The patient was admitted to hospital for an appendectomy. While recovering from the anaesthetic she received second and third degree burns to her feet from hot water bottles placed in her bed. The hospital was found liable for the negligence of the nurses who did not test the temperature and placed them without orders. It was argued that the patient was contributorily negligent in failing to call for help, to disclose an earlier bout of frostbite to her feet and in leaving the hospital early against medical advice. All were rejected by the trial judge. He was of the opinion that the injury occurred to the patient while she was still anaesthetized and that it was not unreasonable to fail to disclose

88. Hôpital Notre-Dame de l'Espérance v. Laurent [1978] 1 S.C.R. 605; affirming [1974] C.A. 543 (Que.).

89. [1948] 1 W.W.R. 113 (Alta. S.C.). Note that the plea of last-clear-chance or ultimate negligence by the defendant against the plaintiff was denied as well.

having frozen feet upon entering hospital for an appendectomy. Furthermore, her leaving hospital had not aggravated her injuries. All in all this patient had acted as a reasonable person. It is possible to see, however, that a patient who fails to disclose a material fact to a hospital or doctor might be found contributorily negligent.⁹⁰ as might a patient who leaves hospital without notice or against medical advice and as a consequence suffers greater injuries.⁹¹

Other conduct by a patient that might bring a finding of contributory negligence⁹² would include failure to return for treatment,⁹³ to seek treatment,⁹⁴ to co-operate during treatment,⁹⁵ or to follow instructions.⁹⁶ However, to date in support there are primarily only obiter comments in case law from both inside and outside Canada. It remains to be seen whether the new vitality of the patient's role in his own health care will result in the law's requiring a higher standard of him.

90. Kouri, supra n. 82 at 50.

91. Meredith, supra n. 16 at 156.

92. Kouri, supra n. 82.

93. See Moore v. Large (1932) 46 B.C.R. 179 at 183 (C.A.); Hôpital Notre-Dame de l'Espérance v. Laurent supra n. 82.

94. See Hampton v. Macadam (1912) 22 W.L.R. 31 at 35 (Sask). See also McDaniel v. Vancouver Gen. Hospital supra n. 20.

95. Antoniuk v. Smith [1930] 2 W.W.R. 721 at 734 (Alta. C.A.).

96. Marshall v. Rodgers [1943] 2 W.W.R. 545 at 554 (B.C.C.A.) where failure to be vaccinated for smallpox was advanced but not seriously pressed.

The issue of contributory negligence must be differentiated from that of joint and several liability. Just as with contributory negligence, all provinces in Canada have legislation⁹⁷ providing for apportionment where an innocent party suffers an injury through the negligence of two or more persons.⁹⁸ An example would be where the patient is injured through the joint negligence of a hospital and a doctor. For procedurally advantageous reasons,⁹⁹ the patient would likely sue both of them, and if both were found to be negligent the court would have to apportion the fault between them. However, the patient, if he had a joint and several judgment against them, would be entitled to recover the full amount of his damages from either defendant. Between themselves the doctor and the hospital would each be liable to make contribution and to indemnify each another to the degree to which each was found negligent. There have been a number of cases where the plaintiff sued only one defendant and that party brought proceedings as third party proceedings against others whom he alleged would or should have to contribute for compensation due to a patient.¹⁰⁰ This is an extremely complicated area in which judges,

97. See supra n. 82 and Quebec Civil Code, Art. 1106.

98. See Parmley v. Parmley [1945] S.C.R. 635 where a doctor and dentist were held equally liable; each to bear one-half of the patient's loss. See also Jeannotte v. Couillard (1894) 3 Q.B. 461 (Que.).

99. For example, the opportunity to examine for discovery and discover documents. See supra Chapter 1. See also Duxbury v. Calgary [1940] 1 W.W.R. 174 (Alta. C.A.).

100. MacKenzie v. Vance (1977) 2 C.C.L.T. 63 (N.S.C.A.); Johnson v. Vancouver Gen. Hospital [1973] 1 W.W.R. 361; affirmed [1974] 1 W.W.R. 239 (B.C.C.A.). Kane v. Haman [1971] 1 O.R. 294 (S.C.); see also Griffiths, Claims for Contribution or Indemnity As Between Hospitals, Doctors and Others [1963] L.S.U.C. Spec. Lec. 237.

lawyers and academics are all complaining and requesting law reform.¹⁰¹

4. Expiry of Limitation Period

This has proven to be an effective defence for doctors and hospitals for it has stopped a number of actions.¹⁰² It is a procedural rather than a substantive defence and has its basis in statutes although

101. For an excellent discussion see Klar, supra n. 85. The classical work is Williams, Joint Torts and Contributory Negligence, Stevens & Sons, London, 1951.

102. It has barred actions in the following cases: Mumford v Children's Hospital of Winnipeg [1977] 1 W.W.R. 666 (Man. C.A.); Murphy v. Mathieson (1976) unreported (Alta. Dist. Ct.), Belzil J.; Karderas v. Clow supra n. 14; Johnson v. Vancouver Gen. Hospital supra n. 100; Carrier v. McCowan (1971) 24 D.L.R. (3d) 105 (Alta S.C.); McKay v. Winnipeg Gen. Hospital [1971] 1 W.W.R. 65 (Man. Q.B.); Philippon v. Legate [1970] 1 O.R. 392 (C.A.); Radclyffe v. Rennie [1965] S.C.R. 703; McArthur v. Sask. Cancer Commn. (1958) 27 W.W.R. 152 (Sask. Q.B.); Burk v. S., B., and K. (1951) 4 W.W.R. 520 (B.C.S.C.); Winn v. Alexander [1940] O.W.N. 238 (H.C.); Boase v. Paul [1931] 4 D.L.R. 435 (Ont. S.C.); Pierce v. Strathroy Hospital (1924) 27 O.W.N. 180 (H.C.); Tremeer v. Black [1924] 2 W.W.R. 97 (Sask. C.A.); Town v. Archer supra n. 84; Miller v. Ryerson (1892) 22 O.R. 369 (C.A.). It has been an issue in the following cases: McKenzie v. Vance, supra n. 100; Cusson v. Robidoux [1977] 1 S.C.R. 650; Denton v. Jones (No. 2) (1976) 14 O.R. (2d) 382 (H.C.); Spencer v. Indian Head Union Hospital (1974) 48 D.L.R. 449 (Sask. C.A.); Kushner v. Wellesley Hospital [1971] 2 O.R. 732 (C.A.); Johnston v. Wellesley Hospital (1970) 17 D.L.R. (3d) 139 (Ont. H.C.); Gloning v. Miller (1953) 10 W.W.R. 414 (Alta S.C.); Dixie v. Royal Columbian Hospital [1941] 1 W.W.R. 389 (B.C.C.A.); McIntosh v. Homewood Sanitarium [1940] O.W.N. 118 (H.C.); Offord v. Ottawa Civic Hospital [1938] O.W.N. 274 (H.C.); Hochman v. Willinsky [1933] O.W.N. 79 (H.C.); Harkies v. Lord Dufferin Hospital [1931] 2 D.L.R. 440 (Ont. S.C.); Prescott v. McArthur (1928) 62 O.L.R. 385 (H.C.).

the principles of statutory interpretation are found in the case law. The defendant for whom it is successful has not been tried and exonerated: rather, he has not been tried. Limitation periods exist for nearly all legal actions and refer to the time within which the action must be commenced, after which it will be said to be time-barred and will not be heard by a court except on that issue.

Excellent practical reasons exist for establishing time limits within which suits must be brought: memories fade, records are lost, witnesses may die or become impossible to locate. This is the so-called stale evidence rationale. Furthermore, justice requires that there come a time when potential liability for negligence ought no longer to hover over one's head. But much dissatisfaction exists with the present law because meritorious claims may be sterilized prematurely. Legislative reform has been called for and has begun in some provinces.¹⁰³ Thus within the near future the time periods themselves will no doubt be changed which together with the fact that there are significant differences in the law between provinces in terms of length of time, exceptions, and even the statutes in which the times are set out, complicate a thorough discussion of the topic. Fortunately, there are two excellent and current sources on the present law: Williams, Limitations of Actions in Canada¹⁰⁴ and McLaren, Of Doctors, Hospitals and Limitations - The Patient's Dilemma.¹⁰⁵ Thus,

103. Limitations Act, 1975 (B.C.), c. 37; Draft Proposed Limitations Act in Attorney General of Ontario, Discussion Paper on Proposed Limitations Act (1977).

104. (1971).

105. (1973) 11 Osgoode Hall L.J. 85.

only general observations will be made about the defence.

The limitation period varies for different types of action for generally it is the basis for the claim not the type of defendant that marks the suit. So an action brought against the doctor in contract or assault and battery must be brought within the normal limitation rules for those claims.¹⁰⁶ In the former it is usually six years from breach of the contract,¹⁰⁷ while in the latter it is normally two years from the commission of the tort.¹⁰⁸ Lawyers, architects and engineers are by tradition sued in contract¹⁰⁹ and therefore are vulnerable for a six year period for any breach in professional duty to a client. A hospital may be sued in contract or in tort¹¹⁰ but a doctor or other health care professional is to date most often sued in negligence.¹¹¹

Doctors, hospitals and now certain other health professionals are favoured by a shorter limitation period in most Canadian provinces. An action must be brought against a doctor within one year from the date of termination of services, except in Manitoba,¹¹² Newfoundland,¹¹³

106. Note there is some authority for the proposition that all actions against a doctor fall within the "malpractice" definition.

107. Williams, supra n. 104 at 45.

108. Id. at 59.

109. See Schwebel v. Telekes [1967] 1 O.R. 541 (C.A.).

110. Rozovsky, Canadian Hospital Law 14 (1974).

111. See supra Chapter 3.

112. Medical Act, R.S.M. 1970, c. M-90, s. 43.

113. Medical Act, 1974 (Nfld.), No. 119, s. 25 [am. 1975, No. 13, s. 2].

the North West Territories, the Yukon¹¹⁴ and recently British Columbia¹¹⁵ where the time is two years. This preferential treatment originated in Ontario in the late nineteenth century, when the Ontario legislature amended¹¹⁶ the Medical Act¹¹⁷ by setting a shorter period of one year (the norm was six years at that time) and by setting the termination of services as the time from which the period was to be calculated. The special rule with respect to doctors spread to all the other Canadian jurisdictions and similar protection was established for hospitals and other health care professionals, but the phenomenon was limited to Canada.¹¹⁸ In an early assessment of the growth of the law an Ontario Judge said:¹¹⁹

It is not an Act respecting limitation of actions, but one passed mainly for the benefit of the medical profession; nor is the provision in question an amendment of the provision of any such statute, but simply a provision for the special protection of the registered members of that profession.

There is no evidence why the termination of services was chosen as a commencement date but it is probable that it was thought to provide

114. Limitation of Actions Ordinance, R.O.N.W.T. 1974, c. L-6, s. 3(1)(d); Medical Professional Ordinance, R.O.Y.T. 1976, c. M-6, s. 11(1).

115. See supra n. 103, s. 3(1)(a).

116. Act to Amend the Medical Act, 1887 (Ont.), c. 24, s. 2.

117. R.S.O. 1877, c. 142. The isolation of this from other limitation law precluded flexibility. See McLaren, supra n. 105 at 90.

118. McLaren, supra n. 105 at 87-89.

119. Miller v. Ryerson supra n. 102 at 373.

some certainty.¹²⁰ By comparison, time begins to run in ordinary negligence actions from the time of the occurrence of the damage. However, under the special rule for doctors a patient must know of his injury and sue within one year from the termination of services. Thus when the cause of action is "hidden", as when an object is left in the body and remains inert, adverse consequences of negligent treatment are slow in developing, or a negligent diagnosis is made which delays treatment, the patient may be unaware of the damage he has suffered.¹²¹ Moreover, there is a certain perversity for both parties when the termination of services is the critical date. The doctor-patient relationship is strained when a doctor is "caught" by continuing to treat his patient and similarly a patient may not receive the best care.

Specifically, the time may be affected by the scope given to the word 'services'. An Alberta decision¹²² has broadened the scope for recovery by holding that the subsequent treatment need not be a necessary or normal extension of the treatment in respect of which negligence is alleged. A doctor left his forceps in a patient who continued to consult him as a family doctor. Indeed, he removed the forceps. Had the patient not continued to consult the doctor she would

120. See Tremeer v. Black *supra* n. 102 at 100.

121. *Id.*; Miller v. Ryerson *supra* n. 102 at 373.

122. Gloning v. Miller *supra* n. 102; see also McKenzie v. Vance (1977) 2 C.C.L.T. 63 (N.S.C.A.) where the limitation period was extended against a doctor whose later "services" were the filling out of Workers' Compensation Board forms. But see Town v. Archer *supra* n. 84 where the patient only returned to complain and was time-barred.

have been beyond the time period. Clearly, however,¹²³

[b]y any contemporary standards of sound social policy the equivocal situation of the patient in these cases is entirely unsatisfactory and calls out for remedy.

The author of this quote recommends that there be (1) no disparity between limitation periods for different torts (2) a common starting point in all negligence actions, viz. the occurrence of damage, (3) the coalescence of all limitation periods into one statute, and (4) a belated discovery rule.¹²⁴

The last recommendation deals with the hidden cause of action and recognizes that even a reasonable patient may not discover the damage until the limitation period has passed. A number of attempts have been made to decide what conditions and contingencies ought to be placed on a patient if he is to be allowed to pursue a doctor under such a rule, perhaps years after the event.¹²⁵ Law reform is progressing in Ontario,¹²⁶

123. McLaren, supra n. 105 at 93.

124. Id. at 97-98.

125. See Manitoba's solution in the Limitation of Actions Act, R.S.M. 1970, c. L-150 following the English Limitations Act, 1963 (U.K.), c. 47 and a critique in McLaren, supra n. 105 at 95-97; see Health Disciplines Act, 1974 (Ont.), c. 47, s. 17 and a critique in Sharpe, Periods of Limitation and Medical Malpractice: A New Act for Ontario (1975) 23 Chitty's L.J. 145. Concern has been expressed in medical circles over the extension of the limitation period. See Geekie, The Crisis in Medical Malpractice: Will It Spread to Canada? (1975) 113 Can. Med. Assoc. J. 327.

126. Ontario Law Reform Commission, Report on Limitation of Actions (1969).

British Columbia¹²⁷ and Alberta,¹²⁸ and it seems likely that McLaren's recommendations will be of some influence. The ultimate choice will be made by the legislatures on the basis of policy, and it is to be hoped that the final solution will satisfactorily balance the interests of all concerned.

127. Law Reform Commission of British Columbia, Report on Limitations, Part 2 (1974).

128. Williams, Report to the Institute of Law Research and Reform on Limitation of Actions, University of Alberta (1970); University of Alberta, Institute of Law Research and Reform, Working Paper, Limitation of Actions (1977).

CHAPTER VII

PROOF OF NEGLIGENCE

1. Introduction

In all civil actions the plaintiff has the onus of proving the elements of the action brought. Accordingly in a medical negligence action against a doctor or hospital¹ it is the patient who must prove the essentials of negligence.² If the action brought was based on one of the intentional torts³ such as battery or false imprisonment or was in the nature of a contract action,⁴ then the onus of proving the essentials of these actions would similarly rest on the patient.

Whatever the nature of the action, the essentials are proven by means of evidence introduced by the parties to the action. Evidence includes the sworn testimony of witnesses or the parties to the

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1. Note that the word 'hospital' is used to cover the employees, such as nurses, for whom the hospital will be responsible. See Chapter 9.
 2. See supra Chapter 5. For an excellent discussion of the burden of proof in Quebec see Mecs, Medical Liability and the Burden of Proof, An Analysis of Recent Quebec Jurisprudence (1970), 16 McGill L.J. 163.
 3. Supra Chapter 3.
 4. Sopinka and Lederman, The Law of Evidence in Civil Cases 403-406 (1974). Supra Chapter 3.

action,⁵ documentary evidence and exhibits.⁶ Generally any evidence which is relevant to the case will be admissible, that is, it will be heard by the court. However, our legal system, in the course of its evolution, has developed a complex body of rules that determines which evidence is admissible and which is inadmissible. This body of rules also governs the question of how much weight ought to be attached by the court to various kinds of admissible evidence. Only a few of the rules, those most important to the medical negligence action, will be discussed in this chapter.

The law of evidence is currently under study by both federal and provincial law reformers⁷ and it is expected that the law will be clarified and, hopefully, simplified.

2. Evidence

(a) Witnesses

The patient attempts to make at least a prima facie case of medical negligence through the sworn testimony of himself and his witnesses.

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5. Including that from discovery: supra Chapter 1.
 6. These are articles such as forceps, sponges, needles and are introduced into evidence during the testimony of witnesses.
 7. Law Reform Commission of British Columbia, Interim Report on the Law of Evidence (1973); Ontario Law Reform Commission, Report on the Law of Evidence (1976); Civil Code Revision Office, Report on Evidence (1975); Law Reform Commission of Canada, Report on Evidence (1977). Also, the Uniform Law Conference of Canada has appointed a Task Force to prepare a draft report on evidence.

Usually his own testimony will be used to prove the duty owed to him and the injury suffered⁸ and may help to establish the breach of the standard of care and the causal link between the alleged negligence and the injury. However, establishing these latter two matters will also require the testimony of experts, who will be doctors from the same speciality as the defendant if possible. The court must be satisfied that the expert called is by training, practice and experience particularly knowledgeable in the area in issue, and the party calling such a witness must so qualify him.⁹

The proof of breach of standard of care and causation by the means of expert testimony is the most difficult part of the patient's case.¹⁰ Even if there is no difficulty in obtaining the necessary experts¹¹ both counsel and the court must come to grips with complex medical terminology and information. Furthermore, the defendant too will make use of expert evidence to prove that he met the standard or to disprove causation.¹² Unfortunately, in the modern adversarial context an expert witness is too often seen and believes himself to be

8. See Richardson v. Nugent (1918) 40 D.L.R. 700 (N.B.C.A.) where a new trial was ordered because the patient was allowed to exhibit an open wound to the jury. See also Gray v. LaFleche [1950] 1 D.L.R. 337 (Man. K.B.) where a trial judge refused to allow the injuries of a child who had suffered a deformed penis from a circumcision to be shown to the jury.

9. See infra Chapter 8 for a description of how this is done.

10. Haines, The Conduct of a Malpractice Action [1963] L.S.U.C. Spec. Lec. 273 at 289.

11. See infra regarding the difficulty of obtaining witnesses.

12. Note that in most jurisdictions the number of expert witnesses is restricted with leave to apply for more in appropriate cases.

a weapon for one side of the action. His true role is simply to assist the impartial court in determining the facts. Nevertheless, the quality of the expert evidence is critical to the proof or disproof of negligence;¹³ in many cases in which the plaintiff has been unsuccessful it is clear that his expert evidence was weak.¹⁴

Although a court has the discretion ultimately to accept or reject expert evidence,¹⁵ it is not likely to reject it unless the issue is non-technical or involves the taking of precautions, or unless the experts' opinions are divided.¹⁶

A basic rule of evidence is that a witness can testify only to that which he has actually perceived through his own senses. Information from other sources is referred to as hearsay evidence and is not admissible unless it falls into one of the generally recognized exceptions to the hearsay rule. For example,¹⁷ a doctor who examined a patient when he was admitted to hospital is asked to describe the patient's injuries. The evidence is admissible. But if the doctor proceeded to state the opinion given by the radiologist on an x-ray examination of

13. Samuels, Expert Forensic Evidence (1974) 14 Med. Sci. L. 17.

14. See, for example, Wilson v. Swanson [1956] S.C.R. 804; McDaniel v. Vancouver Gen. Hospital [1934] 4 D.L.R. 593 (P.C.).

15. Anderson v. Chasney [1950] 4 D.L.R. 223 (S.C.C.); Crits v. Sylvester [1956] S.C.R. 991; Price v. Milawski (1977) 1 L.M.Q. 303 (Ont. C.A.); Meredith, Malpractice Liability of Doctors and Hospitals (1957). See also Chapter 6.

16. Villemure v. Turcot [1973] S.C.R. 716. For the attitude of the Appeal Court when the medical evidence has been split, see Hay v. Bain [1925] 2 D.L.R. 948 (Alta. A.D.); Gray v. Caldeira [1936] 1 W.W.R. 615 (P.C.).

17. Meredith, supra n. 15 at 47.

the patient, that would be hearsay and subject to objection. The example points out the main reason for the rule, which is that the best evidence regarding the x-ray would come from the radiologist who should be called and who could then be cross-examined. Two exceptions to the hearsay rule of importance to doctors are that 1) a patient's statement as to his physical or mental sensation or feeling is admissible evidence of the existence of that state (but not the patient's story of how and by whom the symptoms were caused)¹⁸ and 2) a patient's declaration in anticipation of death made in extremis¹⁹ may be admissible in a homicide case.

Witnesses qualified by the court as experts can testify beyond simply what they perceived with their own senses. Besides providing basic information to the court for its comprehension of the scientific or technical issues, the expert is allowed to state his opinion and conclusions.²⁰

(b) Documents

Apart from the oral evidence of witnesses the plaintiff or defendant may rely on documentary evidence, such as the hospital record, reports of test results, or the doctor's office records to assist him

18. Id. at 48; Sopinka and Lederman, supra n. 4 at 112.

19. Meredith, supra n. 15 at 47.

20. Id. at 309; see also Taylor v. Gray (1937) 11 M.P.R. 588 at 598-99 (N.B.C.A.).

in the action. A party wishing to procure or produce any of these, or other, documents has at his disposal the process of discovery of documents, discussed earlier.²¹ Thus a doctor or hospital is bound to disclose any documents made with regard to the patient's care and treatment. However, documents brought into existence to assist a defendant or his legal advisors are privileged²² as to their contents unless legislation states otherwise.²³ In addition, legislation in most provinces provides the mechanism by which a patient can obtain a copy of his hospital record,²⁴ and there is also legislation in most provinces allowing hospital records into court as evidence provided they are made in the usual and ordinary course of hospital business and at the time of the act or event recorded, or within a reasonable time afterwards.²⁵ The admissibility of hospital records in court has

21. Supra Chapter 1.

22. Crits v. Sylvester [1955] O.W.N. 243 (H.C.).

23. Evidence Act, R.S.B.C. 1960, c. 134, ss. 12, 13 [am. 1976, c. 33, s. 86]; Manitoba Evidence Act, R.S.M. 1970, c. E150, s. 50 [am. 1971, c. 70, ss. 2, 3; 1976, c. 69, s. 18]; Evidence Act, R.S.O. 1970, c. 151, s. 52; Saskatchewan Evidence Act, R.S.S. 1965, c. 80, s. 30 [am. 1969, c. 51, s. 2; 1972, c. 105, s. 1; 1973-74, c. 97, s. 2].

24. See, for example, Alberta Hospitals Act, R.S.A. 1970, c. 174, s. 35, as amended.

25. Evidence Act, R.S.B.C. 1960, c. 134, s. 43 [am. 1968, c. 16, s. 5]; Manitoba Evidence Act, R.S.M. 1970, c. E150, s. 58; Evidence Act, R.S.N.B. 1973, c. E-11, s. 49; Evidence Act, R.S.N.S. 1967, c. 94, s. 22; Evidence Act, R.S.O. 1970, c. 151, s. 36; Saskatchewan Evidence Act, R.S.S. 1965, c. 80, s. 30 [am. 1969, c. 51, s. 2; 1972, c. 105, s. 1; 1973-74, c. 97, s. 2]; Canada Evidence Act, R.S.C. 1970, c. E-10, s. 30(1).

been confirmed in the case law.²⁶

The hospital record's admission as an exception to the hearsay rule, whether by virtue of statute or case law, raises the issue as to the weight to be given to it. In a very important case, Ares v.

Venner²⁷ the Supreme Court of Canada said:

Hospital records, including nurses' notes, made contemporaneously by someone having a personal knowledge of the matters then being recorded and under a duty to make the entry or record should be received in evidence as prima facie proof of the facts stated therein.

Thus we see judicial reform of the law by the creation of an exception to the hearsay rule in regard to hospital records. The effect of the decision is that what is stated on the record becomes evidence for the party putting it in. To challenge it opposing counsel has to call as his witness the person who made an entry, who can then be cross-examined by the party who put the hospital record into evidence. This is a peculiar reversal of the usual procedure. Normally, a witness who has information is called by the party attempting to prove the fact and then cross-examined by the party challenging the fact. A further criticism of the decision is that it admits not just objective record-keeping such as vital signs but also subjective observations about the

26. Joseph Brant Memorial Hospital v. Koziol (1977) 2 C.C.L.T. 170 (S.C.C.); Aynsley v. Toronto Gen. Hospital [1968] 1 O.R. 425 (H.C.); Adderley v. Bremner [1968] 1 O.R. 621 (H.C.). See also Sopinka and Lederman, supra n. 4 at 88-90.

27. (1970) 14 D.L.R. (3d) 4 at 16 (S.C.C.).

patient, which should be subject to cross-examination.²⁸ While the law of evidence needs reform, decisions such as Ares only serve to contribute to the confusion.²⁹

(c) Admissions

In addition to documents and the testimony of witnesses the patient may rely on admissions made by the doctor or hospital. These may occur in the pleadings or, as is more frequent, during examination for discovery or during cross-examination at trial. Such evidence is very significant, because it is presumed that no one would admit something against his own interest if it were not true. Furthermore, there is no doubt that the doctor in the medical negligence action is the best authority on what he did, how he did it, and why he did it.³⁰ He more than anyone else likely knows whether or not his conduct was sub-standard.

However, while admissions of sufficient import to decide the case one way or the other are regular fare in Hollywood trials, they rarely

28. Thompson v. Toorenburgh (1973) 50 D.L.R. (3d) 717 (B.C.C.A.). An excellent example of how critical subjective assessments by nurses may be to the outline of an action, see Park v. Stevenson Memorial Hospital Ont. H.C., Holland J., 1974 (unreported).

29. A critique of the case is found in Sopinka and Lederman, supra n. 4 at 78-80. Note that it appears to have been overlooked in Schweizer v. Central Hospital (1974) 6 O.R. (2d) 606 (H.C.).

30. Waltz and Inbau, Medical Jurisprudence 70 (1971); see also Joseph Brant Memorial Hosopital v. Koziol supra n. 26.

occur in real life. Fatal admissions are only obtained through thorough preparation, skilled advocacy and fortuitous circumstances.

(d) Conclusion

When all the plaintiff's evidence has been put before the court the critical question of whether he has established a prima facie case must be considered. To satisfy this test the plaintiff must have adduced some evidence which is more consistent than not with negligence on the part of the defendant;³¹ the facts must raise an inference of negligence. Once the prima facie case has been established, the defendant must then meet the inference of negligence by proving any defences he has available,³² in a fashion similar to that in which the plaintiff has attempted to prove his case: the sworn testimony of himself and his expert witnesses, relevant documents, and admissions by the plaintiff.

In contrast to criminal cases, in which the matter must be proven beyond a reasonable doubt, the standard of proof required in a negligence case, as in all civil actions, is that the plaintiff must prove his case on a balance of probabilities.³³ Thus at the end of the

31. Nathan, Medical Negligence 105 (1957).

32. See supra Chapter 6.

33. Parkin v. Kobrinsky (1963) 46 W.W.R. 193 (Man. C.A.). In McDaniel v. Vancouver Gen. Hospital supra n. 14 [1934] 4 D.L.R. 593 at 594 an erroneous statement was made that the onus of proof was the criminal one. See De Paoli v. Richardson [1936] 2 W.W.R. 183 (Alta. A.D.).

trial the judge or jury³⁴ must weigh all of the evidence adduced by both sides and decide whether the plaintiff has proven on a balance of probabilities that the defendant was negligent.³⁵

3. Difficulties of Proof

(a) Direct and Circumstantial Evidence

A patient who wishes to establish his case before the court must, as we have seen, prove the essentials of his action whatever they may be before he can succeed. In order to prove the essentials of his action he will try to establish the existence of certain facts. Any fact sought to be established in support of an essential of an action is referred to as a "material" fact. Direct evidence is testimony or a document which itself establishes a material fact, and circumstantial evidence is evidence which shows the existence of circumstances from which the court may infer a material fact.³⁶ Thus, bits of evidence which of themselves would be of little probative value may when combined justify the court's inference of a material fact.³⁷ To

34. See infra.

35. Nathan, supra n. 31 at 108. Note the civil onus of proof in Holmes v. London Bd. of Hospital Trustees (1977) 17 O.R. (2d) 626 (H.C.); see also Martel v. Hotel-Dieu St.-Vallier; Vigneault v. Martel (1969) 14 D.L.R. (3d) 445 at 448 (S.C.C.).

36. Sopinka and Lederman, supra n. 4 at 31.

37. Grant v Australian Knitting Mills Ltd. [1936] A.C. 85 (P.C.).

illustrate,³⁸ if a patient alleged that he had contracted an infection from the administration of an anaesthetic, direct evidence may not be available to prove whether the infection resulted from the solution, the instruments or the individuals. However, evidence that the solution was properly constituted and handled, and that the individuals exercised proper sterile techniques would lead to the inference that the cause of the infection was a failure to disinfect the instruments.

Direct evidence is of course the best evidence and the case will be stronger if such evidence is available to show precisely how the accident occurred. However, the difficulty in most medical negligence cases is that the full circumstances of the accident are not known to the patient and therefore evidence of this calibre is not often available.³⁹ Even if the circumstances are known, their significance may be unnoticed by the patient who lacks and perhaps cannot obtain the necessary expertise.

But it seems that Canadian courts are reluctant to infer negligence on the basis of circumstantial evidence in medical negligence cases. One reason is probably a concern that patients with little or no direct evidence would sue too easily in the hope that a court would accept circumstantial evidence, thus crowding the courts and placing a difficult burden on the judiciary. Another explanation was offered in Girard v. Royal Columbian Hospital:⁴⁰

38. Nathan, supra n. 31 at 167.

39. See, for example, Radclyffe v. Rennie [1965] S.C.R. 703.

40. (1976) 66 D.L.R. (3d) 676 at 691 (B.C.S.C.).

The human body is not a container filled with material whose performance can be predictably charted and analysed. It cannot be equated with a box of chewing tobacco or a soft drink. Thus, while permissible inferences may be drawn as to the normal behaviour of these types of commodities the same kind of reasoning does not necessarily apply to a human being. Because of this medical science has not yet reached the stage where the law ought to presume that a patient must come out of an operation as well as or better than he went into it [emphasis supplied].

These arguments invite comment. The mere fact that a court should decide to allow the proof of material fact, in a proper case, from cogent circumstantial evidence would not likely open the floodgates of litigation. Circumstantial evidence is given weight in other civil actions⁴¹ and there is no indication that the practice has sparked an abundance of litigation. Furthermore, the judiciary is in an ideal position to control the extent to which circumstantial evidence would be relied upon and a firm stance by the courts in equivocal cases would serve to discourage frivolous suits.

The Girard case suggests that the complexity of the human body militates against the use of circumstantial evidence in medical negligence cases. However the argument passes over the fact that medical science has succeeded to a considerable extent in identifying deviations from normal physiological behaviour to the point where the risks of various complications arising out of certain procedures can often be

41. Sopinka and Lederman, supra n. 4 at 33 and 526.

expressed in terms of a percentage.⁴² The reasoning suggested by this case would have the patient meet his onus in every case by direct evidence alone because the crux of the medical negligence action is always damage to a human body. It is hoped that the courts will take a more moderate view and apply these rules of evidence to medical negligence suits in the same fashion as they are applied in other actions. Otherwise, the effect is to place on patients a higher burden of proof.⁴³

Having said this, a plaintiff in certain medical negligence cases may be able to take advantage of one rule of circumstantial evidence developed for his benefit: res ipsa loquitur.

(b) Res Ipsa Loquitur

(i) Prerequisites

There has been judicial recognition in negligence cases of the hardship on the plaintiff who is attempting to prove negligence when he knows only that an accident has happened and that he was injured. In

42. See Chubey v. Ahsan [1976] 3 W.W.R. 367 (Man. C.A.) where the medical evidence was that in disc surgery in 1 of 7,000 operations an artery is damaged and 50% of these result in death; see also Reibl v. Hughes (1977) 78 D.L.R. (3d) 35; (1978) 6 C.C.L.T. 227 (Ont. C.A.), where the medical evidence was that a patient undergoing arterial surgery was subject to a 14% risk of mortality or morbidity.

43. Where a patient has difficulty getting witnesses, the burden is increased further. See infra.

many instances the details of the accident are known only to the defendant, but sometimes the mere fact that an accident happened will itself give rise to an inference of negligence on the part of the defendant because the event is such that it would be unlikely to occur unless there had been negligence.⁴⁴ The accident "speaks of negligence"; hence the term used for this circumstance: res ipsa loquitur, "the thing speaks for itself".

Variously described as a rule, principle, doctrine and maxim, res ipsa loquitur is applied in Canada as part of the law of circumstantial evidence⁴⁵ and has been called "one of the great mysteries of tort law".⁴⁶

As with much of the law, the essentials of res ipsa loquitur are easy to state but its application is complicated.⁴⁷ The doctrine will only apply when:

- 1) there is no evidence as to how or why the accident occurred,⁴⁸ and

44. Bryne v. Boadle (1863) 2 H. & C. 722, 159 E.R. 299 (Ex.).

45. Sopinka and Lederman, supra n. 4 at 399.

46. Linden, Canadian Tort Law 221 (1977). See 219-252 of this book for an excellent review of the law. This is true despite the fact that it is subjected to analysis by authorities in both the law of torts and evidence. See Sopinka and Lederman, supra n. 4 at 398.

47. Wright, Res Ipsa Loquitur in Studies in Canadian Tort Law 41 (1st ed. Linden, 1968); Fridman, The Myth of Res Ipsa Loquitur (1954) 10 U.T.L.J. 223; Paton, Res Ipsa Loquitur (1936) 14 Can. Bar Rev. 480; Schiff, A Res Ipsa Loquitur Nutshell (1976) 26 U.T.L.J. 451.

48. Most authorities prefer to state (2) and (3) as requirements and (1) as a prerequisite. In medical negligence cases the order in which they are here set out provides the best understanding.

- 2) the accident is such that it would not occur without negligence, and
- 3) the defendant is proven to have been in control of the situation either personally or vicariously.⁴⁹

The possible effects of the doctrine on the onus of proof vary and are best understood by an analysis of the case law on point.

(ii) Application

There are compelling policy reasons for utilizing the doctrine in the medical negligence case. The plaintiff who often knows nothing about the accident, indeed who may have been anaesthetized or very ill,⁵⁰ bears a heavy burden yet may have difficulties getting information and witnesses.⁵¹ The defendant, on the other hand, who knows or ought to know often has easy access to the facts.⁵²

The courts saw difficulties in trying to distinguish between medical accidents which could⁵³ not occur without negligence and those which could and for some time it was uncertain whether res ipsa

49. By "vicariously" is meant by virtue of having responsibility for, or right to control, the wrongdoer.

50. See, for example, Eady v. Tenderenda (1975) 2 S.C.R. 599.

51. See infra.

52. See McLean v. Weir [1977] 3 C.C.L.T. 87 at 95 (B.C.S.C.) where the patient was said to be under a "formidable disadvantage" as a layman suing an expert.

53. Clark v. Wansbrough [1940] O.W.N. 67 at 72 (H.C.); Hughston v. Jost [1943] O.W.N. 3 (H.C.).

loquitur applied in medical negligence cases.⁵⁴ However, it is clear since 1953 and Holt v. Nesbitt⁵⁵ that the courts are to avail themselves of expert evidence as to what is normal and what is not⁵⁶ and that justice demands the application of the doctrine in this context:⁵⁷

It would give to doctors, dentists, and members of other professions an unfair and unwarranted protection in actions where their conduct in the exercise of their profession is called into question. It would permit them to refuse to give an explanation in a Court of justice of a happening which has caused injury to a person, even though the occurrence was of such a kind and description that a reasonable man would naturally infer from it that it was caused by some negligence or misconduct. It would place them in a position in the Courts that in a case such as the present one the defendant could unfairly and unjustly say: "I alone am responsible for all that happened in the course of the operation. I know all the facts from which it can be decided whether or not I used due care. I can explain the happening, but I refuse to do so." To permit a defendant to take such a position in a Court of law would be, in my opinion, a denial of justice to a person who knows nothing of the matter that caused his injury and seeks to recover for the loss suffered by reason of it from the person who possesses full knowledge of the facts.

54. It was said not to apply in Ontario. See Hughston v. Jost *id.* at 6. There are early cases which recognized it might apply: Hodgins v. Banting (1906) 12 O.L.R. 117 (H.C.); McTaggart v. Powers [1926] 3 W.W.R. 513 (Man. C.A.); Sisters of St. Joseph of the Diocese of London v. Fleming [1938] S.C.R. 172; McFadyen v. Harvie [1941] 2 D.L.R. 663 affirmed [1942] S.C.R. 390; Meyer v. Lefebvre [1942] 1 W.W.R. 485 (Alta. A.D.); Cox v. Saskatoon [1942] 1 W.W.R. 717 (Sask. C.A.); Bernier v. Sisters of Service (St. John's Hospital, Edson) [1948] 1 W.W.R. 113 (Alta. T.D.). And cases where it was applied: Harkies v. Lord Dufferin Hospital [1931] 2 D.L.R. 440 (Ont. H.C.); Taylor v. Gray *supra* n. 20; Abel v. Cooke [1938] 1 W.W.R. 49 (Alta. A.D.).

55. [1953] 1 S.C.R. 143. Also Crits v. Sylvester *supra* n. 15.

56. Interlake Tissue Mills Co. v. Salmond [1949] 1 D.L.R. 207 (Ont. C.A.); Hobson v. Munkley (1976) 1 C.C.L.T. 163 (Ont. H.C.).

57. Holt v. Nesbitt [1951] O.R. 601 at 605-606, affirmed [1953] 1 S.C.R. 143.

Nevertheless the courts continue to be cautious in their application of the doctrine in medical negligence cases.⁵⁸ To the old fears of lack of expertise, inability to appreciate the difference between the non-negligent accident and the negligent accident and reluctance to find that there is no evidence as to how the accident occurred⁵⁹ is now added the modern one of increasing the liability of doctors and hospitals to the point of precipitating a "malpractice crisis".⁶⁰ Whether these fears are justified in Canada is not yet clear.

Each of the prerequisites to res ipsa loquitur will now be examined with reference to the cases since Holt v. Nesbitt.

A. The cause must be unknown

By "cause" is meant the cause-in-fact of the injury, including the facts leading up to the injury itself. When the facts of the accident which caused the patient's injury are known, the doctrine is inapplicable as, for example, when a patient suffered burns and scarring from a

58. Tallin, Liability of Professional Men for Negligence and Malpractice (1960) 3 Can. Bar J. 230 at 240. U.S. jurisprudence reveals the same progress, see Hole, Medical Malpractice in New York (1976) 27 Syracuse L.R. 657 at 678.

59. Laidlaw, The Burden of Proof in Malpractice Actions [1963] L.S.U.C. Spec. Lec. 219 at 222. See Kolesar v. Jeffries (1976) 12 O.R. 142, affirmed (sub nom. Joseph Brant Memorial Hospital v. Koziol) 2 C.C.L.T. 170 (S.C.C.).

60. Teplitsky and Weisstub, Torts-Negligence Standards and the Physician (1978) 56 Can. Bar Rev. 121.

carbon dioxide slush treatment for acne.⁶¹ When the plaintiff knows only part of the story he ought to plead and prove what facts he does know and plead res ipsa loquitur when he can go no further.⁶²

However, if there is evidence of the cause of the accident, the patient cannot ignore it and expect to use the doctrine as a substitute for proving his case.⁶³ Furthermore, should the true cause of the accident become known during the trial, the doctrine loses its utility and the case proceeds as an ordinary negligence case.⁶⁴

While there is general agreement on this prerequisite,⁶⁵ the courts must face the fact that there will occasionally be cases where the cause is impossible to pin down, and it may have to be ruled a mystery.⁶⁶

61. Johnston v. Wellesly Hospital (1970) 17 D.L.R. (3d) 139 (Ont. H.C.); see also Kolesar v. Jeffries (1974) 59 D.L.R. (3d) 367, varied 12 O.R. (2d) 142, affirmed (sub nom. Joseph Brant Memorial Hospital v. Koziol) 2 C.C.L.T. 170 (S.C.C.) supra n. 26; Kangas v. Parker [1976] 5 W.W.R. 25 (Sask. Q.B.).

62. It may not be fatal to fail to plead it: Greschuk v. Kolodychuk (1959) 27 W.W.R. 157 (Alta. A.D.). But see David Spencer Ltd. v. Field [1939] S.C.R. 36.

63. McLean v. Weir supra n. 52.

64. Nathan, supra n. 30 at 109.

65. But see the peculiar statement in Sisters of St. Joseph of the Diocese of London v. Fleming supra n. 54 at 177: "It is unfortunate that the maxim res ipsa loquitur, which serves satisfactorily when applied to certain cases in which the cause of the action is known, has become a much overworked instrument in our courts..." [emphasis supplied].

66. Hobson v. Munkley supra n. 56; see also Kolesar v. Jeffries supra n. 61; see also Cavan v. Wilcox (1974) 2 N.R. 618 at 626 (S.C.C.).

B. The accident must speak of negligence

This determination causes the courts the most difficulty. Any person knows that certain events, such as bags of sugar falling on people,⁶⁷ an oil furnace exploding,⁶⁸ or an airplane crashing,⁶⁹ bespeak negligence. But few know whether an artery cut during disc surgery⁷⁰ or an ureter cut during gynecological surgery⁷¹ does. Of course not every medical accident speaks of negligence. Accidents can and do happen without negligence.⁷² The problem is how a judge, a medical layman, is to know the non-negligent accident from the negligent one. The best evidence would be the testimony of experts that the accident that caused damage would not normally occur without negligence on the part of the defendant, and if it is possible to obtain this evidence the patient ought certainly do so.⁷³ However, to require such evidence in every case would be to misinterpret the doctrine and apply it more strictly to medical negligence cases than to

67. Scott v. London & St. Katherine Docks Co. (1865) 3 H. & C. 596, 159 E.R. 665 (Ex. Ch.).

68. Kirk v. McLaughlin Coal & Supplies Ltd. (1967) 66 D.L.R. (2d) 321 (Ont. C.A.).

69. Malone v. Trans-Can. Airlines; Moss v. Trans-Can. Airlines [1942] O.R. 453 (C.A.).

70. Kapur v. Marshall (1978) 4 C.C.L.T. 204 (Ont. H.C.).

71. Hobson v. Munkley *supra* n. 56.

72. Crits v. Sylvester *supra* n. 15; McTaggart v. Powers *supra* n. 54.

73. McLean v. Weir *supra* n. 52.

ordinary negligence cases,⁷⁴ for there are some occurrences that, even to a layman, speak of negligence without the confirmation of expert evidence. As was stated in an English case where the patient proved that the doctor had left a swab in her body:⁷⁵

The surgeon is in command of the operation. It is for him to decide what instruments, swabs and the like are to be used, and it is he who uses them. The patient, or, if he dies, his representatives, can know nothing about this matter. There can be no possible question but that neither swabs nor instruments are ordinarily left in the patient's body and on one would venture to say it is proper, though in particular circumstances it may be excusable, so to leave them. If, therefore, a swab is left in the patient's body, it seems to me clear that the surgeon is called upon for an explanation. That is, he is called upon to show, not necessarily why he missed it, but that he exercised due care to prevent its being left there.

Lord Nathan has stated in reflecting upon that case:⁷⁶

All that is necessary is that the occurrence is more consistent with there having been negligence than with there having been none; and the mere fact that the occurrence may have happened without negligence does not preclude the operation of the maxim if the more probable explanation is that there was negligence.

Therefore, while some events may speak directly to the layman of the negligence others may require the interpretation of an expert. If the former, the court can apply the doctrine on its own; if the latter the plaintiff must provide the conduit in the form of an expert witness.

Unfortunately Canadian Judges have not distinctly stated their position on this issue but a reading of the cases indicates that they

74. Fleming, Law of Torts 304 (5th ed. 1977).

75. Mahon v. Osborne [1939] 1 All E.R. 535 at 561 (C.A.).

76. Supra n. 31 at 116.

are applying the doctrine. Accidents which have been held to speak of negligence have involved broken needles,⁷⁷ misplaced injections causing paralysis⁷⁸ and circulatory complications,⁷⁹ burns,⁸⁰ sponges⁸¹ and forceps⁸² left behind, anaesthesiological mishaps,⁸³ and surgery causing vocal impairment⁸⁴ and facial paralysis.⁸⁵ Accidents which have been held not to speak of negligence have involved arterial surgery causing paralysis,⁸⁶ ureter damage during tubal ligation,⁸⁷ disc surgery causing arterial damage and death⁸⁸ and dental extraction causing a broken jaw.⁸⁹

The courts must be aware of the basic difficulty that while the critical question is whether such an accident would normally occur with-

77. Cardin v. Montreal (1961) 29 D.L.R. (2d) 492 (S.C.C.).

78. Martel v. Hôtel-Dieu St.-Vallier; Vigneault v. Martel supra n. 35.

79. Cavan v. Wilcox supra n. 66.

80. Abel v. Cooke supra n. 54; Harkies v. Lord Dufferin Hospital supra n. 54; Sisters of St. Joseph of the Diocese of London v. Fleming supra n. 54.

81. Karderas v. Clow (1973) 32 D.L.R. (3d) 303 (Ont. H.C.); Holt v. Nesbitt supra n. 55.

82. Taylor v. Gray supra n. 20.

83. Holmes v. London Bd. of Hospital Trustees supra n. 35.

84. Finlay v. Auld [1975] S.C.R. 338.

85. Eady v. Tenderenda supra n. 50.

86. Girard v. Royal Columbian Hospital supra n. 40.

87. Hobson v. Munkley supra n. 56.

88. Kapur v. Marshall supra n. 70.

89. Fish v. Kapur [1948] 2 All E.R. 176; Fletcher v. Bench reported in [1973] 4 Brit. Med. J. 117 at 118.

out negligence, it may be an impossible one for an expert to answer, especially if such an accident has never occurred before. This and the difficulty of cataloguing res ipsa loquitur situations call out for flexibility and the use of common sense,⁹⁰ as put succinctly by Fleming:⁹¹

the maxim contains nothing new; it is based on common sense, since it is a matter of ordinary observation and experience in life that sometimes a thing tells its own story.

C. The negligence must be the defendant's

The patient must be able to prove that the defendant was in control of the state of affairs out of which the negligence arose. Thus the defendant may be a doctor, a hospital or an employee, but the patient must not only allege the negligence but also point out the defendant.⁹² Thus where a patient was burned when alcohol ignited during a cauterization the doctrine was held not to apply because many persons were engaged in the procedure and she could not point to any one of

90. Wright, supra n. 47 at 48 and 61. In 1906, for example, it was held that deformities were a very common result of fractures even with the most skilled treatment of modern surgery; hence, res ipsa loquitur should not apply; see Hodgins v. Banting supra n. 54. Today, deformities might well speak of negligence.

91. Supra n. 74 at 302.

92. Hôtel-Dieu de Montréal v. Couloume [1975] 2 S.C.R. 115. See Nathan, supra n. 31 at 110 and Wright, supra n. 47 at 55.

them.⁹³ In the modern medical setting with team treatment the patient may have great difficulty in pointing to any one person. Attempts to assist the patient have led to innovative jurisprudence.⁹⁴ In an American case, Ybarra v. Spangard,⁹⁵ a patient who suffered a shoulder injury during appendix surgery sued the entire surgical team. He was non-suited at the trial but on appeal the case was sent back for a new trial and res ipsa loquitur was held to be applicable. Recently in Ontario a court⁹⁶ attempted to extend the case of Cook v. Lewis,⁹⁷ holding that because a nurse's negligence precluded a determination of the patient's cause of death it was up to her and her employer, the hospital, to prove a cause of death unrelated to their negligence. But the Supreme Court of Canada⁹⁸ overruled the decision and reiterated that the negligence must be "brought down" to one or other of the defendants by the plaintiff. The court did leave for the future the possibility that the Cook v. Lewis rule could be

93. McFayden v. Harvie supra n. 54. See also Morris v. Winsbury-White [1937] 4 All E.R. 494 (K.B.) where the doctor sued had not been in charge of the patient the whole time.

94. See Wright, supra n. 47 at 50-54.

95. (1944) 154 P. 2d 687 (Cal. S.C.). Wright has criticized this decision supra n. 47 at 54.

96. Kolesar v. Jeffries (1976) 12 O.R. (2d) 142 affirmed (sub nom. Joseph Brant Memorial Hospital v. Koziol) 2 C.C.L.T. 170 (S.C.C.).

97. [1951] S.C.R. 830. This case held that when a person has been injured by one of two persons, in circumstances where both have acted carelessly and the effect is to make it impossible for the plaintiff to show which one's negligence caused the injuries, then both should be held liable unless they can exculpate themselves.

98. Joseph Brant Memorial Hospital v. Koziol supra n. 26 and Klar, Annotation.

invoked to help a patient in the right case which, it appears, would have to have very special circumstances. It would be a case where the patient could implicate both defendants in the negligence but be unable to show the cause as flowing from the actions of one or the other of them.⁹⁹ Given the court's caution in invoking res ipsa loquitur it can be assumed that Cook v. Lewis will rarely be applied, but where the above facts exist it could be of some assistance in resolving the causation issue.

However, the patient is greatly assisted in his search for the appropriate defendant by pre-trial inquiries, especially the examination for discovery. The opportunity afforded to question the doctor or officers or employees of the hospital is sufficient reason for naming all possible negligent actors as defendants and discontinuing afterwards against those who have no place in the action. The practice is not a happy one for the fostering of a better relationship between the professions but it is suggested that it is preferable to extending the doctrine as was done in the American case¹⁰⁰ or has been suggested in dicta in an English case.¹⁰¹

99. Klar, id.

100. Supra n. 95.

101. See Roe v. Minister of Health [1954] 2 Q.B. 66 (C.A.) at 82 per Denning L.J.: "If an injured person shows that one or other or both of two persons injured him, but cannot say which of them it was, then he is not defeated altogether. He can call on each of them for an explanation". For a comment see Wright, supra n. 47 at 54.

(iii) Effect

Assuming the prerequisites for the application of the doctrine have been met, the next issue is its effect of the onus of proof in a medical negligence case.

On this point the case law is fairly consistent: the doctrine causes an inference to be drawn that the defendant was negligent¹⁰² and that the defendant, to counter the inference, must offer an explanation of the incident as consistent with no negligence as with negligence.¹⁰³ The Supreme Court of Canada has cautioned strongly that the effect of the doctrine ought to be kept at a reasonable level:¹⁰⁴

It appears to me that in medical cases where differences of expert opinion are not unusual and the sequence of events often appears to have brought about a result which has never occurred in exactly the same way before to the knowledge of the most experienced doctors, great caution should be exercised to ensure that the rule embodied in the maxim res ipsa loquitur is not construed so as to place too heavy a burden on the defendant. Each such case must of necessity be determined according to its own particular facts and it seems to me that the rule should never be applied in such cases by treating the facts of one case as controlling the result in another, however similar those facts may be.

The doctrine has been only rarely held to have the effect of placing on the defendant an onus of disproof of negligence in medical

102. For an excellent statement see Holmes v. London Bd. of Hospital Trustees *supra* n. 35.

103. Finlay v. Auld *supra* n. 84 at 343.

104. Cavan v. Wilcox [1975] 2 S.C.R. 663 at 674.

cases,¹⁰⁵ although it frequently happens that a defendant will do so, even in cases in which the doctrine is not strictly applicable.¹⁰⁶ This is so because such a defence is of course virtually unassailable.

If the defendant offers a satisfactory explanation, then the basic burden of proof remains with the plaintiff who, without more evidence, will not succeed in proving his case on a balance of probabilities.¹⁰⁷ However, it would be an imprudent defendant who offered no explanation, because the effect at a minimum would strengthen the inference of negligence¹⁰⁸ and could possibly result in a finding that the plaintiff had successfully proven his case¹⁰⁹ or at least prevent a non-suit.¹¹⁰

The defendant's explanation need not prove exactly what happened so long as the theory advanced is supported by reasonable testimony. Accordingly, where a defendant testified and called "ample medical evidence to support the finding that the injection was given without

105. But see Cardin v. Montreal (1961) 29 D.L.R. (2d) 492 at 495; McKay v. Royal Inland Hospital (1964) 48 D.L.R. (2d) 665 at 670 (B.C.S.C.).

106. See, for example, McLean v. Weir *supra* n. 52 and Picard, Annotation.

107. Cavan v. Wilcox *supra* n. 66 at 628.

108. Mahon v. Osborne *supra* n. 75. For a comment see Wright, *supra* n. 47 at 53.

109. Karderas v. Clow *supra* n. 81 at 312; Taylor v. Gray 11 M.P.R. 588 at 606, see *supra* n. 20.

110. McKay v. Gilchrist (1962) 35 D.L.R. (2d) 568 (Sask. C.A.).

negligence"¹¹¹ the explanation was found adequate. Similarly it was held that the defendant had successfully discharged his burden of rebutting the inference where he and his medical witnesses testified that it would have been impossible for him in the circumstances to have caused the damage which formed the basis of the complaint.¹¹² On the other hand, a pure hypothesis by the defendant (found to be an unreliable witness) with no support from other witnesses was held not to be an adequate explanation¹¹³ nor was an explanation which revealed a failure to take precautions on the part of the defendant.¹¹⁴ The extremes of the adequacy and inadequacy of explanations are not difficult to see from the cases but the middle area remains muddy, and at least one Judge has recognized the need for clarification.¹¹⁵ Factors that ought to be relevant include whether the defendant testifies, whether any evidence is available to substantiate the explanation, the time at which the theory or explanation was first advanced, and the credibility of the theory.¹¹⁶ The doctrine of res ipsa loquitur is simply a means of assisting the court in having all

111. Cavan v. Wilcox *supra* n. 66. It is interesting that the Court of Appeal held the explanation inadequate based on its assessment of the defendant nurse who had no recollection of the procedure she had used.

112. Finlay v. Auld *supra* n. 84.

113. Martel v. Hôtel-Dieu St.-Vallier; Vigneault v. Martel *supra* n. 35.

114. Crits v. Sylvester *supra* n. 15.

115. Kolesar v. Jeffries (1974) 59 D.L.R. (3d) 367 (Ont. H.C.), *per* Haines J.

116. Holmes v. London Bd. of Hospital Trustees *supra* n. 35.

the relevant evidence brought before it. Properly applied it need not be feared by the doctor or hospital nor ought it to be seen by the patient as a means of resuscitating a dead action.

(c) Obtaining Witnesses

A plaintiff in an action against a doctor or hospital often has difficulty in obtaining expert witnesses to testify on his behalf. In the United States, where much is written about the problem, the difficulty has been attributed to a so-called "conspiracy of silence"¹¹⁷ among members of the medical profession. This view, however, oversimplifies the causes of the phenomenon, which are more numerous and complex than some writers would have us believe.

It is important to remember at the outset that the plaintiff in a medical negligence action is not in a unique position. Obtaining witnesses is a difficulty which arises in all kinds of litigation. While the presence of witnesses, especially expert witnesses, is critical to the just determination of any dispute,¹¹⁸ there are factors present in all lawsuits which tend to discourage persons from volunteering to testify. First, there is a trend today to keep to one's self and resist involvement in social problems or the affairs of

117. Belli, Ready for the Plaintiff (1957) 30 Temp. L.Q. 408.

118. Haines, The Medical Profession and the Adversary Process (1973) 11 Osgoode Hall L.J. 41. The importance of the medical witness to the court was stressed by Scott in Canadian Medical Protective Association, Annual Report 1975 at 23.

others. Second, the legal process requires time for being interviewed, preparing reports, reviewing notes and records and waiting in court to testify. To many, especially professionals, time is money and this sizeable demand on time is resented. Third, the experience of giving testimony in the witness box can be less than enjoyable. The expert will have to expose his credentials and may be questioned about them, which he may feel is demeaning or even destructive to his professional status. Cross-examination is generally unpleasant for the witness who may find his judgment or credibility called into question, and may feel he is not being permitted to give a complete answer.

In addition to these factors, there are others in the action between a patient and his doctor. First, there is no doubt that there is a feeling of brotherhood among the members of any profession, and indeed in view of the education, employment environment and, to a degree, the background of the individuals involved it would be surprising if there were not. Second, the sorts of cases which go to trial are precisely those about which doctors are reluctant to testify. Cases in which the negligence is clear and there is no defence do not go to trial because the patient will be compensated by a settlement with a protective association or malpractice insurer. Similarly, cases in which there appears to be no negligence or where there is an unsailable defence do not go to trial because the patient's hopes of success are overshadowed by the cost of bringing the action.¹¹⁹

119. The Canadian Medical Protective Association refuses to settle claims unless liability is clear. They will not settle for "nuisance value". An easy settlement policy has been cited as one of the reasons for the U.S. malpractice crisis. See Haines, *supra* n. 118 at 44.

Generally it is only those cases in which the negligence alleged or the defence put forward or both are tenuous which go to trial¹²⁰ and these often involve matters of judgment,¹²¹ decisions made under pressure¹²² or procedures taken which seemed reasonable at the time.¹²³ Doctors hearing of such cases may think, "there but for the Grace of God go I" and naturally resist standing in judgment of their colleagues.

The issue also tends to become clouded by aspects of the legal process and in particular its application to the medical negligence suit which irritate both patients and doctors. The power of the writ of subpoena, which is an order in the name of the Sovereign compelling a witness to appear in court or face a fine or possible imprisonment, is resented by many witnesses.¹²⁴ Also, the legal action by a patient against his doctor may have strong emotional overtones arising out of the basic nature of the doctor-patient relationship. Further, to the patient's misunderstandings of the legal process is added the mystery

120. See Haines, *id.* at 42 where he states that the majority of cases going to trial involve "a terribly grey area where the law may see negligence but medicine sees merely an unexpected occurrence in a very inexact art".

121. Ostrowski v. Lotto (1972) 31 D.L.R. (3d) 715 (S.C.C.).

122. Wilson v. Swanson *supra* n. 14.

123. Anderson v. Chasney *supra* n. 15.

124. In British Columbia, Manitoba, Ontario and Saskatchewan, a doctor may give evidence in writing (or by way of medical report) instead of appearing in court. See *supra* n. 23. See Elliot, Medical Evidence (1968) 16 Chitty's L.J. 343; Lightbody, Doctor in the Courtroom? (1973) 31 Advocate 269; Smookler, The Law (1973) Medical Post, Oct. 14. See also Meredith, *supra* n. 15 at 36.

of medicine and the patient may feel that the legal and medical professionals involved are closer to each other than he is to either of them.

Certainly there is evidence of a reluctance of doctors and health care professionals in Canada to testify¹²⁵ but as has been shown, the "conspiracy of silence"¹²⁶ explanation is incomplete; there are many reasons for the aversion to appear as a witness.

In recognition of this, steps have been taken with the goal in mind of bringing doctors and lawyers together for the benefit of themselves and patients.¹²⁷ These include the creation of medical-legal societies, joint professional committees, inter-professional codes,¹²⁸ undertakings by national and provincial medical associations to provide witnesses where necessary,¹²⁹ and resolutions by doctors and their medical protective associations to testify when requested. Nevertheless, the reluctance to testify will always be with

125. See, for example, McKeachie v. Alvarez (1970) 17 D.L.R. (3d) 87 at 93 (B.C.S.C.); but see Girard v. Royal Columbian Hospital (1976) 66 D.L.R. (3d) 676 at 693 Rev. 483; Province of Ontario, Attorney-General's Committee on Medical Evidence in Court in Civil Cases, Report (1965). An empirical study in Ontario showed Ontario doctors to be reticent: Gray and Sharpe, Osgoode Hall Medical Legal Questionnaire, 1971; see (1973) 11 Osgoode Hall L.J. 1.

126. One author has labelled it "the infernal silence that besets the medical profession": Grange, The Silent Doctor v. The Duty to Speak (1973) 11 Osgoode Hall L.J. 81.

127. See Louisell and Williams, Medical Malpractice, Matthew Bender, New York, 1969 at 9-11.

128. See, for example, Medico-Legal Society of Toronto, Inter-Professional Code (1977).

129. See, for example, Canadian Medical Association, Code of Ethics; see also Marshall, Medical Evidence in Malpractice Actions (1970) 18 Chitty's L.J. 6 at 9 and 11.

us to a degree, and the lawyer must cope with it in a manner constructive to his client's case and within the best ethical practice of both professions.¹³⁰

The preparation of a medical negligence suit against a doctor or hospital is an arduous and difficult task, and the following are some practical suggestions to assist with the problem.¹³¹

Once the lawyer has all the facts, some time ought to be spent with medical dictionaries and texts in an attempt to get a grip on the medical aspects of the case. Engaging the services of qualified medical professionals for assistance ought to be considered.¹³² This expert assistance will often have to be sought by the lawyer himself and may only be obtainable in exchange for an undertaking that the expert will not be called to testify. The experts should not be relied upon to develop the case for the plaintiff, but should be asked to evaluate theories as to what may have happened, postulated by the lawyer after thorough research.¹³³

130. For the perspective of a Canadian doctor-lawyer see Marshall, id.

131. For an excellent outline and explanation of many more points that can be set out here see Stewart, The Preparation and Presentation of Medical Proof [1955] L.S.U.C. Spec. Lec. 155. See also Haines, supra n. 10.

132. See Haines, supra n. 10.

133. Kramer, in The Negligent Doctor, Crown Publications, New York, 1968, outlines his method: "I have a theory about medical experts, particularly in malpractice cases, that has proved its worth through my years of experience. The best hope of getting one [to testify for the plaintiff] always a difficult matter - is to do the necessary medical research in advance and ferret out the authorities and data that fortify your claim. It is one thing to ask a doctor for his opinion as to whether or not there was careless or negligent practice, but it is quite another to spell out in detail the acts of negligence, support with literature and then ask him if he is in accord. When you have done the latter, the expert is usually more receptive."

Experts who are willing to testify should of course be treated with the appropriate degree of professionalism. The following is a list of matters which ought to be performed to make the experience of the expert as pleasant as possible. Make specific arrangements as to required reports, accompanied by the patient's consent and the fee. Give maximum notice of the time of trial. Brief the expert before trial as to procedure, the necessity of qualifying him, the questions to be asked of him and the likely areas of cross-examination. Settle beforehand the amount of the witness fee. Make arrangements to take the evidence of your expert with as little delay as possible. After the trial, pay the witness promptly along with a letter of appreciation and information as to the disposition of the case. In short, be courteous. It is to be remembered that a lost case can as easily be the result of poor advocacy as poor evidence, and the lawyer who blames only the latter may be deceiving himself.

(d) The Jury

In any legal action there are to be decided questions of both law and fact. The judge always rules on questions of law, and when he sits without a jury, also determines the questions of fact. If a jury is present, it will decide questions of fact and be directed on the law by the judge. The judge has the discretion to "withdraw the case from the jury" if he believes that the plaintiff's evidence is insufficient,

and can dismiss the action,¹³⁴ but if the case goes to the jury it is the task of the jurors to assess the credibility of the witnesses and where there is a conflict in testimony to decide which version is to be accepted.¹³⁵

Neither the trial judge nor a Court of Appeal should substitute its own opinion on those matters for that of the jury. The test is not whether the verdict appears to the judge or appeal court to be correct but whether the jury as reasonable persons could have reached such a decision. Thus, the decision of a properly instructed jury carrying out its assignment is often impossible to upset.¹³⁶

However, the use of civil juries is dying out in Canada.¹³⁷ The procedure is cumbersome, expensive, time consuming and leaves to inexperienced persons the difficult job of assessing damages. In medical negligence¹³⁸ cases there is a concern that juries tend to unfairly favour the plaintiff.¹³⁹ Furthermore, the ability of a jury to understand the complex evidence that may attend such a suit has been

134. Fields v. Rutherford (1878) 29 U.C.C.P. 113 (C.A.).

135. McNulty v. Morris (1901) 2 O.L.R. 656 at 658 (Div. Ct.).

136. Eady v. Tenderenda (1974) 3 N.R. 26 (S.C.C.) upholding a jury verdict; but see McQuay v. Eastwood (1886) 12 O.R. 402 (C.A.) where a jury verdict was reversed.

137. See Morrow v. Royal Victoria Hospital (1971) 23 D.L.R. (3d) 441 at 450; reversed on other grounds 42 D.L.R. (3d) 233 (S.C.C.); see also Sopinka and Lederman, supra n. 4 at 6.

138. See Haines, supra n. 118 at 43 note 3 for an exhaustive list of cases ruling on applications for jury trials.

139. Jackson v. Hyde (1869) 28 U.C.Q.B. 294; Key v. Thomson (1868) 12 N.B.R. 295 at 306 (S.C.).

used as a basis for rejecting applications for jury trials,¹⁴⁰ and in Alberta there is legislative authority for trial without a jury where the trial might involve a technical investigation.¹⁴¹ Thus, in most provinces in Canada a medical negligence case will be heard by a judge alone.¹⁴²

140. See, for example, Marshall v. Curry (No. 2) [1933] 3 D.L.R. 198 (N.S.S.C.); Durkin v. Les Soeurs de Charite [1940] 1 W.W.R. 558 (Man. C.A.); Duxbury v. Calgary [1940] 1 W.W.R. 174 (Alta. A.D.); York v. Lapp (1967) 65 D.L.R. (2d) 351 (B.C.S.C.).

141. Jury Act, R.S.A. 1970, c. 194, s. 32 [am. 1971, c. 56, s. 9]; See also Wenger v. Marien (1977) 78 D.L.R. (3d) 201 (Alta. S.C.).

142. There are those who call for the return of the civil jury because they believe that the patient's interests are not being adequately protected by the present tort system. Teplitsky and Weisstub, Torts-Negligence Standards and the Physician (1978) 56 Can. Bar Rev. 121. For a recent case where a jury was used see Child v. Vancouver Gen. Hospital [1970] S.C.R. 477.

CHAPTER VIII

THE DOCTOR IN COURT

1. Introduction

Differences in the education and experience of doctors and lawyers have sometimes led to misunderstandings between the professions. The doctor's education emphasizes the assimilation of complex factual knowledge and objective scientific inquiry; the lawyer's emphasizes the acquisition of a special type of reasoning powers and the development of adversarial and debating techniques. Doctors see themselves as co-operating in the common objective of preserving or restoring a patient's health, whereas the practice of law in both the courtroom and the office depends upon debate and challenge to resolve disputes. It has therefore been suggested that the legal process and particularly the adversary system is alien to doctors.¹

These generalizations, even if only partially true, demonstrate that there is a risk that each profession may feel it will never understand the other. However, the basic commitment of both doctors and lawyers is to serve those who seek help; this ought to be seen by members of both

1. For an excellent discussion see Louisell and Williams, Medical Malpractice, Matthew Bender, New York, 1977 at 5 - 11. See also Haines, The Medical Profession and the Adversary Process (1973) 11 Osgoode Hall L. J. 41; Griffiths, Some Comments on Forensic Medicine (1966) 9 C. B. J. 306.

professions as a common objective. The challenge of maintaining understanding and goodwill between the professions can be met with ease if the intelligence and insight possessed by the members of both professions is directed toward an appreciation of the world in which each functions.

To this point in the book the doctor's role in court has been seen primarily as a defendant or as an expert witness in a medical negligence suit and these roles will be discussed in more detail presently. However, a doctor could be summoned by a court of law to act in any of a number of capacities.² In civil cases his knowledge of the patient's medical condition or prognosis is frequently required by the court³ as an aid to assessing damages or benefits, determining testamentary capacity, granting divorce, custody and adoption, or determining standard of care, approved practice and error of judgment. In criminal cases, his evidence may be required to establish injuries, the cause of death, or

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2. The importance of his evidence has been recognized for a very long time. See, for example, Slater v. Baker (1767) 2 Wils. 359, 95 E.R. 860 (C.P.).
 3. For the difficulty faced by a court without such evidence see Robinson v. Englot [1949] 2 W.W.R. 1137 at 1142 (Man. K.B.). Statutes in some jurisdictions provide for the admission of medical reports which have been signed by a legally qualified practitioner. See Evidence Act, R.S.B.C. 1960, c. 134, ss. 12, 13 [am. 1973, c. 31; 1976, c. 33, s. 86]; Manitoba Evidence Act, R.S.M. 1970, c. E - 150, s. 50 [am. 1971, c. 70, ss. 2-3]; Evidence Act, R.S.O. 1970, c. 151, s. 52; Saskatchewan Evidence Act, R.S.S. 1965, c. 80, s. 30 [am. 1969, c. 51, s. 2; 1972, c. 105, s. 1; 1973-74, c. 97, s. 2] see also supra Chapter 7.

the mental or physical state of the accused.⁴ In all cases, his role is to assist the court in arriving at a just decision.⁵

A unique role for the medical expert which has rarely been utilized in Canada is that of independent court expert.⁶ Rules of procedure⁷ in many jurisdictions provide that a court expert may be appointed to assist the court in determining some facts in issue upon the application of a party or on the court's own motion. While the process has its roots deep in the common law, its use in tort cases is viewed with suspicion by modern lawyers and judges because of fears that too great weight might be attached to the findings of such an expert.⁸ But as one judge has

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4. There are many excellent articles dealing with psychiatric evidence. See, for example, Goldberg and Zisman, The Admissibility of Psychiatric Evidence on the Issues of Identity and Credibility (1976) 33 C.R.N.S. 1; Manning and Mewet, Psychiatric Evidence (1976) 18 Crim. L.Q. 325; Silverman, Psychiatric Evidence in Criminal Law (1972) 14 Crim. L.Q. 145.
 5. The Canadian Medical Association, Code of Ethics (1975) sets this out as a responsibility to society.
 6. See Sopinka and Lederman, The Law of Evidence in Civil Cases 331-335 (1974); see also Jacobs, The Court Expert - Rule 218 (1975) 13 Alta. L. Rev. 475.
 7. Supreme Court Rules, Alta. Reg. 390/68 (1968) [am. Rules 218, 235]; Supreme Court Rules, B.C. Reg. 310/76 (1976) [am. O. 36, Rule 43 O. 55, Rule 19]; Queen's Bench Rules, Man. Reg. 26/45 (1945) [am. Rule 351(2)]; Rules of the Supreme Court, S.O. Regs. 1963, N.B. Reg. 90 [am. O. 35, Rule 5, O. 36, Rules 4, 43, O. 55, Rule 19]; Judicature Act, R.S. Nfld. 1970, c. 187, s. 18; Judicature Act, 1972 (N.S.), c. 2, s. 32 and Rules of the Supreme Court, Rule 23, R. Regs O. 1970, Reg. 545 [am. Rule 267]; Quebec Civil Code of Procedure Arts. 414-424.
 8. See, for example, Lord Denning's comments in Re Saxton [1962] 3 All E.R. 92(C.A.) on an equivalent rule; see also Samuels, Expert Forensic Evidence (1974) 14 Med. Sci. Law 17. This is especially true in a medical negligence suit; Hay v. Bain [1924] 1 D.L.R. 1165 (Alta. S.C. T.D.).

said:⁹ "It is rather quaint that we should expect our judges to be expert in everything." This is especially true in regard to medical evidence where the experts may not be in accord, or where the judge may have grave doubts about the evidence of the experts.¹⁰ There are two reported cases where a medical court expert has been properly used,¹¹ both from Quebec. In Bergstrom v. G.¹² the trial judge had before him the testimonies of "two schools of doctors, to wit: the orthopedic surgeons and the vascular specialists." He suggested that an expert be appointed, to which the parties agreed, and the doctor so appointed after reviewing the testimony and the exhibits gave his views on the treatment given to the patient, and the court agreed with his opinion. In Boivin v. Remillard¹³ where the medical evidence was in conflict a psychiatrist was appointed by the judge to examine a man to decide whether he was fit to manage his affairs, and the resulting opinion was accepted.

Any doctor who is appointed as an independent court expert does, no doubt, carry as heavy a responsibility as the judge or jury.

9. Haines, *supra* n. 1.

10. See, for example, Villemure v. Turcot [1973] S.C.R. 716.

11. See also Featherstone v. Grunsven [1972] 1 O.R. 490 (C.A.) where prior to trial the judge appointed an independent medical expert to examine a plaintiff in a personal injuries case. He used the opinion but did not reveal it to counsel. On appeal a new trial was ordered.

12. [1967] C.S. 513 (Que.)

13. [1969] C.S. 203 (Que.).

2. As Witness

(a) Interviews

A doctor who is to be called as a witness must be interviewed personally by the lawyer, probably on more than one occasion.¹⁴ The most benefit is obtained from this contact after each has reviewed all available and relevant notes, documents and records. The interview is of value to both participants. The lawyer has the opportunity to explore the doctor's evidence and opinions, which will assist him in preparing for cross-examination. This is also the time to establish the limits of the doctor's evidence and opinions, and to go over with him the questions to be asked in examination-in-chief. The doctor ought at this time to be made aware of what will happen in the courtroom, and of other aspects of the case or the legal process. His qualifications should be reviewed and some time spent on the subject of cross-examination: the rationale, the scope and the pitfalls.

(b) Qualifications

When the doctor is first called to testify, he must be qualified as an expert witness.¹⁵ The lawyer will ask the doctor to outline his

14 If acting for a patient suing in a medical negligence suit, see Haines, The Conduct of a Malpractice Action [1963] L.S.U.C. Spec. Lec. 273.

15. See generally, Sopinka and Lederman, supra n. 6 at 309-313.

training, degrees, publications, experience, and possibly his steps in keeping abreast of medicine or increasing his expertise by taking courses, reading journals, participating in conferences and so on. In many cases the lawyer for the opposite side will simply state that he accepts the qualifications, which means that this recital need not take place unless the lawyer calling the witness wishes to have the qualifications made obvious to the court and put on the record of the trial. After the doctor outlines his qualifications the lawyer for the opposing side may cross-examine him on them but this rarely occurs in Canada. Doctors subjected to a review of their qualifications or possibly to cross-examination on them may resent what they see as a questioning of their competence.¹⁶ However, because our courts rely so heavily upon the evidence of experts in medical negligence cases, it must be certain in the individual case that the witness is qualified as an expert in the relevant area.

(c) Giving Evidence

(i) Nature of evidence

A doctor who has treated a patient may give evidence not only of his observations, diagnosis and treatment but, because he is an expert, can go further:¹⁷

16. See, for example, Chubey v. Ahsan [1975] 1 W.W.R. 120 at 121; affirmed [1976] 3 W.W.R. 367 (Man. C.A.).

17. Viscount Simon, The Doctor in the Witness Box [1953] 2 Brit. Med. J. 4826 approved in Meredith, Malpractice Liability of Doctors and Hospitals 80 (1956).

Most witnesses are called to prove ordinary facts, like the facts of an accident which they observed, or the conduct of others which they have seen. But a duly qualified doctor is usually an expert witness, and employs his skill and knowledge to express a medical opinion and draw conclusions from symptoms he has observed from facts that have been proven. The law permits him to do this because the tribunal, judge, or jury, is not in itself qualified to draw such conclusions and therefore relies on a specialist to tell it what the proper deduction is.

A modern authority states it this way:¹⁸

An expert is usually called for two reasons. He provides basic information to the court necessary for its understanding of the scientific or technical issues involved in the case. In addition, because the court alone is incapable of drawing the necessary inferences from the technical facts presented, an expert is allowed to state his opinion and conclusions.

However, an expert can give opinion evidence only on matters within his field of expertise. In every case the court has the final discretion to accept or reject expert evidence¹⁹ and can draw inferences from the failure to call such evidence.²⁰

(ii) Examination-in-chief

If a medical-legal report has been prepared and there have been pre-trial conferences between the doctor and lawyer the examination-in-chief

18. Sopinka and Lederman, supra n. 6 at 309.

19. Ostrowski v. Lotto (1972) 31 D.L.R. (3d) 715 at 721 (S.C.C.); Chubey v. Ahsan, supra n. 16 at [1975] 1 W.W.R. 128; Badger v. Surkan [1973] 1 W.W.R. 302 at 313 (Sask. C.A.); see also Meredith, supra n. 17 at 35 and 64; Shaw, The Law and the Expert Witness (1976) 69 Proceedings of the Royal Society of Medicine 1.

20. Ostrowski v. Lotto (1970) 15 D.L.R. (3d) 402 at 409 (Ont. C.A.); affirmed (1972) 31 D.L.R. (3d) 715 (S.C.C.).

of the doctor should contain no surprises for the doctor or the lawyer who calls him. While testifying the doctor is free to refer to his own notes to refresh his memory,²¹ including his medical-legal report, and may also refer to texts, periodicals, or other authorities if he bases his opinion on them.²² Two types of questions are of interest: leading and hypothetical.

Leading questions²³ are those which suggest the answer and are not permissible in examination-in-chief unless used only to introduce evidence not in issue. For example, the lawyer when beginning his examination-in-chief may say, "Doctor, did the plaintiff consult you in your professional capacity?" On the other hand, leading questions are permissible on cross-examination²⁴ and thus a doctor must listen carefully to the question and be sure he understands it before replying.

If a doctor called as an expert has no personal knowledge of facts which are in dispute he can still be asked his opinion through the use of a hypothetical question.²⁵ The hypothetical fact situation is actually formulated from facts proven at trial and must be put to the expert in a clear, uncontradictory manner. He is asked to assume that certain facts exist and asked for his opinion on a specific issue such as what the

21. Meredith, supra n. 17 at 45.

22. R. v. Anderson (1914) 16 D.L.R. 203 at 219-220 (Alta. S.C.); Reference re Sections 222, 224, 224A of The Criminal Code (1971) 3 C.C.C. (2d) 243 at 254 (N.B.C.A.); Sopinka and Lederman, supra n. 6 at 326-328.

23. See Sopinka and Lederman, id. at 481-485; Meredith supra n. 17 at 45.

24. Sopinka and Lederman, supra n. 6 at 498.

25. Id. at 314-315.

diagnosis might be. These questions may be long and complicated and the doctor should be very certain that he understands what facts he is being asked to assume before he gives his opinion.

(iii) Cross-examination

Cross-examination is the part of testifying that doctors seem to fear most.²⁶ It is the heart of the adversary system and the doctor knows that the goal is to elicit replies that weaken or destroy the evidence given in examination-in-chief, that support the cross-examining lawyer's case, or even that discredit the doctor as a witness.²⁷

Caution should be exercised by the lawyer who, by cross examination, may seem only to make the other side's case stronger.²⁸ Experienced lawyers realize the risk of "taking on" an expert, and anecdotes about the question that should never have been asked abound. It goes without saying that the lawyer should know the medical evidence as thoroughly as possible but to have his own medical expert in court is helpful and his presence may prevent exaggeration by witnesses called by the other side. Many excellent books are available to assist the lawyer

26. Gibson, Courts and Doctors (1952) 30 Can. Bar Rev. 498 at 499.

27. Sopinka and Lederman, supra n. 6 at 496-521; Meredith, supra n. 17 at 48-49.

28. Stewart, The Preparation and Presentation of Medical Proof [1955] L.S.U.C. Spec. Lec. 155 at 171.

in developing the art of advocacy,²⁹ but some advice to medical witnesses³⁰ might be of assistance to the medical reader.

- (a) Listen to the question and be sure you understand it before answering. Questions and answers are the foundations of a law suit.
- (b) Answer the question fully. If you are cut off or feel you are being restricted ask to be permitted to finish your answer.³¹
- (c) Do not hesitate to say you do not know the answer or to refuse to answer a question outside the scope of your expertise.
- (d) Do not get angry; be firm but polite.
- (e) You are not an advocate for the side that called you. Your duty is to assist the court. You are not expected to be an expert on the legal implications of your evidence.
- (f) Address yourself to the judge when answering. Seek his assistance if you feel you are being unfairly treated by a lawyer

29. See, for example, Cecil, Brief to Counsel, Michael Joseph, London, 1972; Harris, Harris's Hints on Advocacy, Stevens, London, 1926; Harris, Illustrations in Advocacy, Stevens and Haynes, London, 1915; Keeton, Trial Tactics and Methods, Prentice-Hall, New York, 1954; Parry, Seven Lamps of Advocacy, Books for Libraries Press, New York, 1968; Stryker, The Art of Advocacy, Simon and Schuster, New York, 1954; Wrottesley, The Examination of Witnesses in Court, Sweet and Maxwell, London, 1961.

30. For excellent practical guides to lawyers see Stewart, supra n. 28; McIsaac, The Presentation of Medical Evidence (1968) 11 C.B.J. 363. If acting for the patient see Haines, supra n. 14. For an equally helpful series of "tips" for the doctor, see Scott, Report of General Counsel for the year 1975 in Canadian Medical Protective Association, Annual Report 1976 23-29.

31. An interesting suggestion offered by one author is for the witness to pause, then make a note. The lawyer who called the doctor can on a re-examination allow him to add to his earlier reply. See Stewart, supra n. 28 at 167-168.

examining you.

- (g) Use simple language. Where medical terms are useful or unavoidable explain them clearly.³²

Many of these points are common sense: they go far in assuring fair treatment of a doctor in court.

(d) The Medical-Legal Report

This document is in most cases the most important one to both doctor and lawyer.³³ It is prepared by the doctor for the information of a lawyer about a patient he has treated or has seen for purposes of evaluating the patient's condition. It assists the lawyer in assessing the patient's case and possible compensation and sets out the evidence that the doctor can substantiate when called as a witness. Furthermore, it may under certain rules of practice³⁴ be reviewed by lawyers on the other side and by other doctors. Since it is prepared for a lawyer in contemplation of litigation it is privileged, that is, exempt from production at trial unless legislation in the jurisdiction provides otherwise.³⁵ Whether the patient is one of the doctor's own or one he is seeing on an assessment basis only, he ought to obtain a written

32. This point has been emphasized by doctors, see Gibson, supra n. 26 at 502, as well as lawyers; see Meredith, supra n. 17 at 46; Stewart, id.

33. See Gibson, supra n. 26 at 499.

34. See, for example, Supreme Court Rules, Alta. Reg. 390/68 [am s. 217].

35. Supra n. 3.

consent to release information. This, together with the fee for the report,³⁶ should be forwarded by the lawyer when the report is requested.

There are no rigid requirements for the organization of the report but many lawyers when requesting a report do suggest a format of topics they wish to be covered.³⁷ As a general rule the following points should be covered by a medical-legal report dealing with personal injuries to a patient.³⁸ First, the report should set out preliminary data including the patient's name, age, address, marital status, occupation, the time, date and nature of the alleged injury and the time of examination. Second, there ought to be as clear a description as possible of the accident and the resultant injury, including a list of all the patient's complaints, including pain. Third, the state of the patient's health prior to the injury and information regarding any previous illness or injury should be set out. Fourth, as far as possible, tests should be carried out in regard to all complaints. There may also have been tests carried out before that are important and arrangements should be made to obtain their results. An experienced doctor has outlined his thoughts on this topic:³⁹

36. The cost of medical-legal reports may be allowed as damages; see Hôpital Notre Dame de l'Espérance v. Laurent [1978] 1 S.C.R. 605.

37. For an example of a model report see Edwards, Medical Reports and the Ontario Evidence Act (1971) 5 Gazette 186.

38. This is essentially the format recommended by Meredith supra n. 17 at 39-43 see also Gibson, supra n. 26.

39. Gibson, supra n. 26 at 500.

Complete physical examination of a patient would take hours or days and is not expected of the examiner. A doctor who is reasonably competent will select the outstanding features of the case and try to concentrate on them. Indeed a complete examination would only lead to confusion: it is the duty of the examiner to select what is relevant and omit the non-essentials. Make the examination of the relevant features as thorough, precise and detailed as possible. If shortening of a limb is present, measure the amount; if there is wasting, note the circumference of the two limbs at corresponding levels. Every doctor should carry a tape-measure. Never omit examination of the central nervous system. A patient seen recently, who complained only of pain in the back, turned out to be an early case of multiple sclerosis. Always carry a safety-pin. Apart from its plebeian virtues as a potential friend in need, it enables you to mark out areas corresponding to sharp and blunt stimuli which may unmask a purely subjective psychotic loss of sensation or a hysterical paralysis. Needless to say, never hesitate to have radiographic examination. That introduces you to a realm of surprises.

Also, a report on diagnosis and treatment should appear where appropriate. It will not be so when the doctor is doing only an assessment of a patient. However, where the doctor has treated the patient for the injuries in issue this portion of the report is important. Besides the obvious report of the diagnosis and the treatment recommended it might be appropriate to indicate whether the suggested treatment has been followed and if not, why not and the probable consequences.

Finally, all of the above information must be "collated and correlated"⁴⁰ by the doctor with a view to explaining and then evaluating the patient's complaints. The lawyer will be interested in the period and degree of temporary incapacity, the degree of permanent disability and the prognosis, including any deformities or possible or probable changes or complications, and opinions of the doctor, for example, that the patient is malingering or suffering from a litigation neurosis. This

40. Id. at 501.

information is better revealed first in a medical-legal report than at trial.⁴¹ An accurate, objective report with reasonable conclusions supported by his findings is a most important asset to the doctor in his testimony,⁴² the lawyer in pleading his case, and the patient in obtaining fair compensation.

3. As Defendant

(a) Advice and Co-operation

The doctor who believes he may have been negligent or knows he has made a "mistake" should not discuss this with the patient until he has reviewed it with someone else.⁴³ A colleague, the Canadian Medical Protective Association, or a lawyer may each or all be appropriate advisors depending upon the circumstances. A doctor has the same right to advice regarding his legal position as any other citizen.

It is human nature to ignore unpleasanties, but unfortunately a defendant cannot afford to ignore a law suit. A doctor who is threatened with a suit, or is served with a statement of claim must act promptly. The usual advice to a defendant is to seek the advice of a lawyer, but

41. Meredith, supra n. 17 at 41-43; Gibson, id.

42. See supra.

43. See, for example, McKeachie v. Alvarez (1970) 17 D.L.R. (3d) 87 at 96 (B.C.S.C.) where the doctor admitted to the patient a few days after surgery that he had cut the radial nerve; see also Walker v. Bedard [1945] O.W.N. 120 (H.C.).

doctors who are members of the Canadian Medical Protective Association should note that it advises against consulting a lawyer without instructions from the Association.⁴⁴ If a lawyer is retained the doctor should supply him with all relevant information including notes and records.⁴⁵ The lawyer cannot handle the defence effectively unless he knows all of the facts both favourable and unfavourable.

An important step in the defence is the selection and interviewing of expert witnesses who might be called by the defence. Obviously, it is the lawyer who knows the evidence necessary for a successful defence and the type of witnesses who will be most effective. However, the doctor can be of great assistance here, and the choice ought to be made by the lawyer in consultation with the doctor. Many lawyers like to have the experts study the case and submit a written opinion prior to the drafting of the statement of defence.⁴⁶ The experts called to testify are usually doctors from the same specialty as the defendant.⁴⁷ The notion that professional brethren provide the evidence upon which a judicial determination of a colleague is made is repugnant to some who say the medical profession is thereby setting its own standards⁴⁸ and that it

44. See Canadian Medical Protective Association Annual Report 1977 at 2. Note the author's closing words in an excellent English book: "One cannot be judge in one's own case; liability should therefore never be admitted": Taylor, The Doctor and Negligence 146 (1971).

45. Dale v. Munthali (1977) 16 O.R. (2d) 532 (H.C.).

46. Meredith, supra n. 17 at 54.

47. See Wilson v. Swanson (1956) 5 D.L.R. (2d) 113 at 126 (S.C.C.) where the evidence of a doctor who was not was held to be inadequate.

48. King, In Search of a Standard of Care for the Medical Profession: The Accepted Practice Formula (1975) 28 Vand. L. Rev. 1213.

breeds a reluctance of one doctor to testify against another,⁴⁹ but, as has been discussed,⁵⁰ the court has the ultimate discretion in dealing with the evidence. Furthermore, the same practice is followed in negligence actions against members of any other profession or skilled group.

(b) Giving Evidence

The doctor defendant's evidence at trial will be primarily factual rather than opinion.⁵¹ He can expect to be asked what he did and why he did it and what he did not do and why he did not do it. The doctor's failure to testify can be extremely deleterious to his defence;⁵² the judge, in the interests of justice, likes to hear the defendant's story and to have the opportunity to assess his credibility and, generally, to "size him up".⁵³ The decision whether to testify or not must be made in consultation between the doctor and his lawyer. While the doctor may

49. Curran, Professional Negligence - Some General Comments (1959) 12 Vand. L. Rev. 535.

50. See authorities listed supra n. 19.

51. Meredith, supra n. 17 at 55. Note that a doctor can properly be asked his expert opinion at his examination for discovery. See Nicholson v. McCulloch (1972) 26 D.L.R. (3d) 384n; affirming (1971) 21 D.L.R. (3d) 126 (Alta. C.A.); Shickele v. Rousseau (1966) 55 W.W.R. 568 (B.C.C.A.); Czuy v. Mitchell [1976] 6 W.W.R. 676 (Alta. C.A.); Hilder v. East Gen. Hospital [1971] 3 O.R. 777 (H.C.).

52. See Holmes v. Bd. of Hospital Trustees of London (1978) 5 C.C.L.T. 1 (Ont. H.C.).

53. See comments on this point in Chubey v. Ahsan supra n. 16.

have a natural reluctance to take the stand it may be prudent that he do so.

The doctor must work with his lawyer in preparing for his examination-in-chief and cross-examination, and the suggestions made earlier to assist the expert witness are appropriate to the doctor as defendant.⁵⁴

Being sued is a painful experience for anyone and in the case of a doctor sued for medical negligence it can be both personally and professionally debilitating. A better understanding of the law and a recognition that others have had the same experience can be of some help.

(c) Costs

A party in whose favour a law suit is resolved is normally awarded "costs" of the action but the judge has a discretion whether or not to make the award.⁵⁵ Costs are a sum calculated according to tables found in the rules of court of each jurisdiction which generally the "unsuccessful party" must pay to the "successful party", but it does not include the lawyer's fee to his client.⁵⁶

While there is some authority that a judge need not award costs against a patient who loses his action against a doctor, the ruling is

54. See supra.

55. Kangas v. Parker (1977) 1 W.W.R. 28 (Sask. Q.B.).

56. See supra Chapter 1.

seldom made. The rationale was well put in a recent case:⁵⁷

Although, for the reasons I have given, I dismiss the plaintiff's action, I do not do so with costs. This case is, in my view, one exceptional circumstances justifying the plaintiff's decision to bring the action. It would not be fair to apply the deterrent of an award of costs to the successful defendant in these circumstances. I am not entitled to provide that the defendant pay the plaintiff the costs of the action, but I do have a discretion, which it is proper for me to exercise now, to provide that there shall be no award of costs.

A judge also has a discretion to order an unsuccessful defendant to pay the costs of a successful one. It has been suggested that in order to get the whole story a patient may have to sue, for example, both a doctor and a hospital.⁵⁸ If the patient should lose against the hospital but win against the doctor, the judge has a discretion to order the doctor to pay to the patient the costs he must pay to the hospital. This will be done only when the patient was reasonable in suing both.⁵⁹

Hopefully, the information and suggestions in this chapter will assist the doctor in adjusting to the courtroom on those occasions when he must appear and facilitate better communication between the professions.

57. Hobson v. Munkley (1976) 1 C.C.L.T. 163 at 179 (Ont. S.C.).

58. See supra Chapter 7.

59. Badger v. Surkan *supra* n. 19. This is called a "Bullock order".
Bullock v. London Gen. Omnibus Co. [1907] 1 K.B. 164 (C.A.).

CHAPTER IX

THE DOCTOR'S LIABILITY FOR THE ACTS OF OTHERS

1. General Principles of Vicarious Liability

Thus far, we have discussed the personal liability of the doctor, but there is another basis upon which he may be liable to a patient who is injured: under some circumstances the law will hold one person responsible for the torts of another. This is referred to as vicarious liability or liability based on respondeat superior (let the principal answer).¹ Liability for the torts of another will only be imposed on a person when he and the tortfeasor are in a relationship which justifies the result, such as employer-employee. The relationships which might lead to a doctor's being held vicariously liable are few compared to those involving a hospital. The hospital serves the patient only through its many employees and the concept of vicarious liability is fundamental to the legal position of such an institution. For this reason, vicarious liability as it relates to the hospital will be discussed in a separate

1. Fleming, The Law of Torts 354 (5th ed. 1977); Fridman, The Law of Agency 233 (4th ed. 1976). In Quebec, Civil Code Art. 1054. See La Responsabilité Civile de L'infirmière (1972) 3 R.D.U.S. 1; Crépeau, La Responsabilité Médicale et Hospitalière dans La Jurisprudence Québécoise Récente (1960) 20 R. du B. 443.

chapter.²

There are clear policy reasons for holding one person³ accountable for the misconduct of another, and an appreciation of these assists in understanding the decisions that follow. The main justification is that the person who engages others to work for him so that his economic interests are advanced should be the one liable for losses which result from the enterprise. Also, he will likely be better able to pay or insure for such accidents. Theoretically, he will see the benefits in accident prevention programs and better employer-employee (or, as they are called in law, master-servant) relationships.⁴ Furthermore, the choice of whether to hire or dismiss an employee is that of the employer.

The effect of holding parties vicariously liable is to render them joint tortfeasors.⁵ This means that both parties are liable but the servant's liability is personal, or direct, whereas the master's is indirect. In practice the patient will likely sue both parties,⁶ but the damages are usually collected from the employer⁷ who has the right

2. See infra Chapter 10.

3. Note that the corporate entity of the hospital is referred to in law as a "person", and so this term is now used to cover both the doctor and the hospital.

4. Fleming, supra n. 1 at 355.

5. See supra Chapter 6.

6. See Fleming, supra n. 1 at 239. Each can then be examined for discovery which can be important where the employer knows little about the accident and it is wished to use the answer at trial.

7. Fleming, supra n. 1 at 356.

to be indemnified by the employee.⁸ However, indemnity is rarely sought by the employer and furthermore, his contract of insurance for the risk of vicarious liability may preclude it.⁹ This seems just in view of the policy reasons for vicarious liability.

Vicarious liability flows from the employer-employee relationship which must be contrasted with the relationship of principal and independent contractor from which vicarious liability does not flow.¹⁰ When an employer engages someone to accomplish a certain result but the work is to be done independently of the employer's supervision, though for his benefit, the relationship is that of principal-independent contractor. An employee is said to have a contract of service whereas the independent contractor is bound by a contract for services.¹¹ The traditional test as to whether a given individual is more properly regarded as an employee or as an independent contractor was the "control" test. The employee is "subject to the command of the master [employer] as to the manner in which he shall do his work,"¹² whereas an independent contractor "undertakes to produce a given result but is not, in the actual execution

8. For it is an implied term of the contract. See Lister v. Romford Ice and Cold Storage Co. [1957] A.C. 555 (H.L.); Fleming, supra n. 1 at 248. But see Morris v. Ford Motor Co. [1973] 1 Q.B. 792 (C.A.).

9. Griffiths, Claims for Contribution or Indemnity As Between Hospitals, Doctors & Others [1963] L.S.U.C. Spec. Lec. 237; see also Fleming, Developments in the English Law of Medical Liability (1959) 12 Vand. L. Rev. 633 at 640.

10. Meredith, Malpractice Liability of Doctors & Hospitals 122-123 (1957).

11. Fleming, supra n. 1 at 358.

12. Yewens v. Noakes (1880) 6 Q.B.D. 530 at 532 (C.A.) quoted by Fleming, supra n. 1 at 358.

of the work, under the order or control of the person for whom he does it."¹³ But the employer-employee relationships have changed dramatically over the years and alternate tests have been canvassed.¹⁴ Many are not helpful but one may be of some utility in this context, namely, the organization test.¹⁵ The person's work is viewed in the light of whether it is an integral part of the organization, because he is employed as part of it, in which case he would make the employer vicariously liable or whether his work, although done for the organization, is not integrated into it but is only accessory to it, in which case he is an independent contractor for whom, as a general rule, the employer is not vicariously liable. This test may be more useful than the control test to analyze the status of the new health care professionals and paramedics as will be seen¹⁶ is more consistent with the modern cases on the vicarious liability of hospitals.

The employer's vicarious liability for an employee extends only to work done "in the course of the employment". While this restriction does set some limit to the liability of the employer it is a very flexible one. For example, liability would still follow an unauthorized mode of performing an authorized task and even a prohibition by an employer may

13. Queensland Stations v. Fed. Commr. of Taxation (1945) 70 C.L.R. 539 at 545 (Aust. H.C.) quoted by Fleming, supra n. 1 at 358.

14. Cassidy v. Ministry of Health [1951] 1 All E.R. 574 (C.A.).

15. Roe v. Minister of Health [1954] 2 Q.B. 66 (C.A.); see Fleming, supra n. 1 at 360.

16. See infra Chapter 10.

not protect him.¹⁷ But liability does not attach to the employer if the employee engages in a independent task of his own.¹⁸ When the employee acts outside of the scope of his employment he is said to be on a "frolic of his own" and the employer is not vicariously liable. While a great volume of perplexing general case law does exist, examples from medical cases are not available to clarify many of these issues. Suppose, however, a nurse employed by doctor or hospital invited a friend to come to her place of work to have her ears pierced, a procedure outside of the scope of her employment. If negligence could be proven against the nurse her employer would have a strong argument that she was acting outside of the scope of her employment, she ought to be solely liable to compensate the injured person.

Thus, in order to arrive at a decision about vicarious liability we see the necessity firstly of characterizing the relationship as that of employer-employee or employer-independent contractor¹⁹ by utilizing the traditional control test or the more modern organization test, and secondly, of considering whether he was acting within the course of his employment. Cases in which a doctor has been vicariously liable will serve to illustrate the application of the rules.

17. Guar. Trust Co. v. Mall Medical Group (1969) 4 D.L.R. (3d) 1 (S.C.C.); for a more detailed discussion see Fleming, supra n. 1 at 364-372.

18. Bugge v. Brown (1919) 26 C.L.R. 110 at 132 (Aust. H.C.).

19. For a discussion of the categories of agent see Fridman, supra n. 1.

2. Relationships With Others and Vicarious Liability

It is possible to confuse the doctor's personal liability with his vicarious liability in some situations. The doctor-patient relationship gives rise to many duties which cannot be delegated.²⁰ For while the doctor is entitled to rely on hospital staff to carry out their duties properly²¹ he cannot delegate his duties to them.²² Furthermore, he will be held personally liable if he is aware, or ought to be aware, that a person is discharging his duty in a careless or negligent manner but takes no action to safeguard the patient.²³ Thus, the doctor's vicarious liability is founded not on his personal negligence but on that of his employee which is imputed to him. It is worth noting that membership by the doctor in the Canadian Medical Protective Association may not cover him for vicarious liability.²⁴

20. Crichton v. Hastings [1972] 3 O.R. 859 (C.A.); see Canadian Medical Protective Association, Annual Report 1974 at 23; see supra Chapter 5.

21. Villeneuve v. Sisters of St. Joseph [1975] S.C.R. 285; Laidlaw v. Lions Gate Hospital (1969) 70 W.W.R. 727 (B.C. S.C.); Karderas v. Clow (1973) 32 D.L.R. (3d) 303 (Ont. H.C.) See supra Chapter 7.

22. Holmes v. Bd. of Hospital Trustees of London (1978) 5 C.C.L.T. 1 (Ont. H.C.); Rozovsky, Canadian Hospital Law 51 (1974).

23. Jones v. Manchester Corpn. [1952] 2 All E.R. 125 (C.A.); see also McQuay v. Eastwood (1886) 12 O.R. 402 (C.P.); Perionowsky v. Freeman (1866) 4F. & F. 977, 176 E.R. 873 (Q.B.).

24. Gravenor, Malpractice and the Paramedical (1975) 41 Canadian Doctor 67 at 69.

(a) Office Staff

A doctor is vicariously liable for torts committed during the course of employment of a receptionist, secretary, office manager, or other officer personnel whom he employs.²⁵ In this regard he is in the same position as any employer with the exception that some patients might assume that a person working in a doctor's office has some medical expertise, especially if in uniform. Such an employee who dispensed medical advice (or medication) could put the doctor in a very vulnerable position²⁶ provided the patient was reasonable in his reliance on the employee and was injured as a consequence. Authorizing employees to act beyond those tasks for which they are trained is a practice fraught with risks for both patient and doctor.²⁷

(b) Nurses

Many doctors engage nurses as employees in their offices and clinics. It is clear that a doctor is vicariously liable for torts committed within the scope of employment of a nurse whom he employs. An

25. Hancke v. Hooper (1835) 7 C. & P. 81, 173 E.R. 37 (Nisi Prius).

26. See Smith v. Auckland Hospital Bd. [1965] N.Z.L.R. 191 at 198 (C.A.); see also Canadian Medical Protective Association, supra n. 20 at 25; McQuay v. Eastwood supra n. 23 where a so-called nurse was not a nurse at all.

27. In a U.S. case an office nurse put a fracture in traction: see Olsen v. McAtee (1947) 181 Ore. 503, 182 P. 2d 979 (S.C.).

interesting case²⁸ arose in Alberta when a patient who suffered from epilepsy but had ceased taking her medication attended at her doctor's office saying that she felt she was about to have a seizure. A nurse employed there placed her on an examination table and left her for one minute in order to get her file. In the nurse's absence the patient had a seizure and fell from the table, breaking her arm. The court held the nurse to be negligent by leaving the patient in a position in which she could suffer harm. She had failed to meet the minimum standard of care to be expected from the professional attendant in a medical clinic. The defendant, a partnership of general practitioners, was held vicariously liable.

In an earlier case from Alberta²⁹ a nurse employed by a doctor was instructed by him to use an x-ray machine to treat a patient suffering from a skin problem. The trial judge found the nurse negligent by failing to warn the patient of the dangers of the treatment, from which the patient suffered an electric shock and burns. The doctor was found to be not personally negligent in his prescription of the treatment, use of the machine or selection and instruction of the nurse, but was found vicariously liable for the nurse's negligence. On appeal³⁰ the nurse was found to be not negligent and thus the action was dismissed.

28. Dowey v. Rotwell and Associates [1974] 5 W.W.R. 311 (Alta. S.C.).
The appeal to the Appellate Division was dismissed on the basis that the court would not disturb the findings of fact of the trial judge.

29. Antoniuk v. Smith [1930] 2 W.W.R. 821 (Alta. C.A.).

30. Id at 729.

These cases illustrate that a nurse-employee will be expected to meet the standard of the reasonable nurse in the circumstances and a failure to do so will render the doctor-employer vicariously liable.

A doctor is not liable for the torts of nurses employed by a hospital and is entitled to rely on the nurses to carry out their duties properly.³¹ A nurse has a duty to execute the doctor's orders and if she does so properly³² yet the patient is injured it may be that the doctor will be held liable because he was personally negligent in giving such an order. In this situation even if she were negligent it would be the hospital that was vicariously liable rather than the doctor.³³

Because of an obiter remark in an English case³⁴ it was thought at one time that a nurse in the operating room might become the employee of the surgeon on the basis that she was a "borrowed servant".³⁵ Rozovsky states³⁶ that there are no reported cases where a hospital has been

31. Villeneuve v. Sisters of St. Joseph *supra* n. 21; Laidlaw v. Lions Gate Hospital *supra* n. 21; McFadyen v. Harvie [1942] 4 D.L.R. 647 (S.C.C.); Armstrong v. Bruce (1904) 4 O.W.R. 327 (Ont. H.C.); R v. Giardine (1939) 71 C.C.C. 295 (Ont. Co. Ct.); see also Morris v. Winsbury-White [1937] 4 All E.R. 494 (K.B.); Ingram v. Fitzgerald [1936] N.Z.L.R. 905 (C.A.).

32. Lavere v. Smith's Falls Public Hospital (1915) 35 O.L.R. 98 (C.A.).

33. Rozovsky, *supra* n. 22 at 19 and 27 note 27: note that the author postulates that a nurse who carries out an order she knows as a professional nurse to be improper is negligent.

34. Hillyer v. The Governors of St. Bartholomew's Hospital [1909] 2 K.B. 820 (C.A.). Quoted with approval in Bugden v. Harbour View Hospital [1947] 2 D.L.R. 338 (N.S.S.C.) although the concept was not applied in the case.

35. Mersey Docks and Harbour Bd. v. Coggins & Griffith [1946] 2 All E.R. 345 (H.L.).

36. Rozovsky, *supra* n. 22 at 19.

relieved of its usual vicarious liability on this basis, and thus in the medical context it appears that the "borrowed servant" rule is not applicable.³⁷

(c) Other Health Care Professionals

Each relationship into which the doctor enters as an employer must be analyzed to ascertain whether the other party is an employee or an independent contractor, since the doctor is generally not liable vicariously for the independent contractor. The issue has risen in importance because of the emergence of paramedical personnel,³⁸ the metamorphosis in some older professions such as nursing,³⁹ and the multi-discipline approach to treatment.⁴⁰ The "nurse" employed by a doctor might not be an employee but a nurse practitioner⁴¹ who by the tests outlined ought more properly to be regarded as an independent contractor. Because so many of these developments are very recent there is no case law to provide precedents and even if there were they would be

37. Meredith, supra n. 10 at 132.

38. Bellenger, The Physician's Assistant, Legal Considerations (1971) 45 Hospitals, No. 11, 58.

39. See Good and Kerr, Contemporary Issues in Canadian Law for Nurses (1973).

40. See Haines v. Bellissimo (1977) 1 L.M.Q. 292 (Ont. S.C.); see also Kennedy v. C.N.A. Assur. Co. (1978) unreported (Ont. H.C.) Linden J.

41. Boudreau, Report of the Committee on Nurse Practitioners, Dept. Nat. Health and Welfare, Ottawa, 1972. See Hall v. Lees [1904] 2 K.B. 602 (C.A.) for an excellent analysis of the relationship of nurses to an association wherein they were found not to be employees.

of questionable value since all such situations will have to be analyzed separately on the basis of their own facts.

There are a few cases which seem to indicate the limits. In a case⁴² that went to the Supreme Court of Canada, a doctor who was part of a medical clinic employed a remedial gymnast⁴³ to whom he gave written instruction regarding exercises for the patient. During exercises administered by the gymnast the patient's knee cap was fractured. The Supreme Court of Canada restored the trial judgment in finding that it was pressure applied by the employee rather than movement by the patient that caused the injury. It is important to note that in applying this pressure the employee was carrying out the authorized treatment, exercises, but in an unauthorized manner, using pressure. Indeed, the written instructions specifically stated that no pressure was to be used. In the result the employer, the medical clinic, was held vicariously liable for the negligence of the remedial gymnast.

In an older case⁴⁴ from Ontario, a doctor was vicariously liable for the negligence of an employee whose job it was to operate the x-ray machine and who had left a cone off the machine, which then caused burns to the patient. By either test the remedial gymnast and the x-ray machine operator were engaged by contract of service and were therefore employees.

42. Guar. Trust Co. v. Mall Medical Group *supra* n. 17.

43. He is referred to id at 2 as a physiotherapist by Judson J. (dissenting) but was not qualified as such: see Hall J. id at 6.

44. Hochman v. Willinsky [1933] O.W.N. 79 (H.C.).

In an old Ontario case⁴⁵ the association of a doctor and a pharmacist was analyzed. The practice was that the doctor would write a prescription which the pharmacist would then fill but the doctor paid the pharmacist and the patient paid only the doctor. The doctor prescribed hydrochloric acid and, in error, the pharmacist's clerk dispensed hydrocyanic acid from which the patient suffered injury. It was found that the doctor was not negligent personally nor vicariously but that the pharmacist was vicariously liable for the error of his clerk. The doctor and pharmacist were held to be separate professionals not even in an employer-independent contractor relationship. This was also the decision in a very recent case⁴⁶ where a pharmacist dispensed formaldehyde instead of the prescribed paraldehyde. It remains to be seen where liability will rest for the torts of other health care professionals.⁴⁷

(d) Other Doctors

A doctor is not vicariously liable for the torts of other doctors⁴⁸ because he normally does not employ them either as employees or even as

45. Stretton v. Holmes (1889) 19 O.R. 286 (Q.B.); see also Jeannotte v. Couillard (1894) 3 Q.B. 461 (Que.).

46. Williams v. Jones (1977) 79 D.L.R. (3d) 670 (B.C. S.C.).

47. See Haines v. Bellissimo supra n. 40 where a psychologist who was on the staff of a medical centre was sued along with a psychiatrist when their patient committed suicide. Since the psychologist was held to be not negligent, the issue of the psychiatrist's vicarious liability did not have to be canvassed.

48. This includes dentists. See Parmley v. Parmley [1945] S.C.R. 635; Kangas v. Parker [1976] 5 W.W.R. 25 (Sask. Q.B.).

independent contractors.⁴⁹ However, the argument has been made that in the case of an anaesthetist engaged for a patient by a surgeon, the surgeon should be vicariously liable for the anaesthetist's negligence. However, in a case in which the surgeon had to assist the anaesthetist by inserting the needle the court held⁵⁰ that each doctor had his separate function and was responsible for the manner in which he discharged it. This same view has been taken of a surgeon and his assistant⁵¹ and of an anaesthetist and his assistant.⁵² Within the hospital setting such assistants may be interns or other house staff who are employees of the hospital and for whom it will be vicariously liable.⁵³ There is an Ontario case⁵⁴ where a surgeon was sued when an intern assisting him with a tonsillectomy accidentally removed the patient's uvula. No liability followed because it was found the patient suffered no injury thereby. However, the trial and appeal courts seemed to have assumed that it was the surgeon who would have been liable. It is not clear whether this would have been based on personal negligence in delegating a

49. Jewison v. Hassard (1916) 10 W.W.R. 1088 (Man. C.A.); see Park v. Stevenson Memorial Hospital (1974) unreported (Ont. H.C.) Holland J. where a doctor who assigned the care of his patient to his doctor-wife for one day was held not vicariously liable for her negligence.

50. Walker v. Bedard [1945] O.W.N. 120 (H.C.).

51. Kardaras v. Clow *supra* n. 21; McFadyen v. Harvie *supra* n. 31; see also MacDonald v. Pottinger [1935] N.Z.L.R. 196 (S.C.).

52. Toronto Gen. Hospital Trustees v. Matthews [1972] S.C.R. 435.

53. Rozovsky, *supra* n. 22 at 15.

54. McNamara v. Smith [1934] 2 D.L.R. 417 (Ont. C.A.).

duty he himself owed to the patient or on vicarious liability, but only the former basis would be consistent with the bulk of the case law.

It is difficult to imagine a doctor binding another to a contract of service⁵⁵ where the employee-doctor would be told not only what to do but how to do it by the employer-doctor. Thus it seems that a case of vicarious liability of one doctor for another⁵⁶ would be very rare.

3. Partnerships

A doctor who practices in a partnership is jointly and severally liable for the torts committed by other partners during the course of

55. The substitute doctor engaged as a locum tenens by a doctor who is absent might, under the right circumstances, fall into this category.

56. A doctor has, however, been held to have engaged another doctor as an independent contractor when he had a contract with a company to furnish medical services to its employees and arranged for another doctor to attend at a work camp for this purpose: see Hamilton v. Phoenix Lbr. Co. [1931] 1 W.W.R. 43 (Alta. C.A.). For cases where it was argued without success that a doctor was an employee see Staple v. Winnipeg (1956) 18 W.W.R. 625; affirmed 19 W.W.R. 672 (Man. C.A.); Jarvis v. Internat. Nickel Co. [1929] 2 D.L.R. 842 (Ont. H.C.); Thompson v. Columbia Coast Mission (1914) 20 B.C.R. 115 (C.A.). See also Daoust v. R. [1969] D.R.S. 594 (Ex. C.C.) where the Crown was held liable for the negligence of a doctor employed at a penitentiary.

the partnership.⁵⁷ Thus one doctor found to be negligent exposes all his partners to liability.⁵⁸ Furthermore the partnership will be vicariously⁵⁹ liable for a negligent employee of the partnership or of one partner. Not all group practices are partnerships, and a doctor is wise to seek legal advice on the advantages and disadvantages. If a partnership is desired a formal agreement ought to be drafted by a competent solicitor.

The general principles of vicarious liability and the law of partnership apply to the doctor and the hospital with the result that either can be liable for the acts of others. However, each individual relationships must be analyzed separately, and recent changes in some traditional relationships make such scrutiny more critical today than ever before.

57. Partnership Act, R.S.A. 1970, c. 271 ss. 12 and 14; Partnership Act, R.S.B.C. 1960, c. 277, ss. 13 and 15; Partnership Act, R.S.M. 1970, c.P-30, ss. 13 and 15; Partnership Act, R.S.N.B. 1973, c. P-4, ss. 11 and 13; Partnership Act, R.S.Nfld. 1970, c. 287, ss. 11 and 13; Partnership Act, R.S.N.S. 1967, c. 224, ss. 12 and 14; Partnerships Act, R.S.O. 1970, c. 339, ss. 11 and 13; Partnership Act, R.S.P.E.I. 1974 c. P-2 ss. 12 and 14; Partnership Act, R.S.S. 1965, c. 387 ss. 12 and 14.

58. Town v. Archer (1902) 4 O.L.R. 383 (K.B.); McKeachie v. Alvarez (1970) 17 D.L.R. (3d) 87 (B.C. S.C.); Badger v. Surkan [1973] T.W.W.R. 302 (Sask. C.A.).

59. Guar. Trust Co. v. Mall Medical Group *supra* n. 17; Dowey v. Rothwell *supra* n. 28

CHAPTER X

THE HOSPITAL

1. Liability in General

Throughout the preceding chapters reference has been made to the legal position of the hospital¹ for in law this institution is a "person" (albeit an artificial one) which has responsibilities to a patient both directly as a corporate entity and indirectly through the acts of its employees. All that has gone before apart from Chapter II and the doctor's duties set out in Chapter V are applicable to the hospital. It can be used by a patient for negligence, breach of contract, assault and battery, false imprisonment and defamation, and it can raise any of the defences outlined² including, to a negligence claim, approved practice, error of judgment, contributory negligence, or to an assault and battery action, consent.³ The conduct of a

1. Throughout this thesis the term hospital has been used as meaning any institution operated for the care and treatment of those requiring medical or surgical attention. See Speller, Law Relating to Hospitals and Kindred Institutions 1 (5th ed. 1971).

2. See supra Chapters 4 and 6.

3. See supra Chapter 4. Although consent to most medical treatment given by the hospital can be implied it has fallen to the hospital to obtain the express consent for the doctor's touching of the patient. (Much difficulty might be avoided by the hospital by requiring the doctor to obtain and place on the patient's hospital record consent to the treatment for which he is responsible).

civil action⁴ and the law and practice in regard to proof⁵ are essentially no different for the hospital as a defendant than for the doctor.

It is necessary, however, to examine the duties owed by the hospital to the patient for they do differ from those owed by the doctor.⁶ and to review those relationships which today will result in the hospital's being held vicariously liable.

2. Direct Liability

The hospital, in former times a place where the improverished ill were deposited for medical attention, has evolved to an institution where the doctor can treat his patient with the assistance of highly skilled and well-organized medical and non-medical personnel with sophisticated equipment in modern facilities. Just as the function of the hospital has expanded so has its responsibility to the patient. These responsibilities may be characterized as duties owed to the patient and a failure to discharge them properly may result in an action against the hospital for breach of contract or negligence. Indeed in many cases both actions are alleged from the same set of facts. For example in a case⁷ where a psychiatric patient injured a

4. See supra Chapter 1.

5. See supra Chapter 7.

6. Note that doctor-patient duties may be important to a hospital where the doctor is an employee of the hospital.

7. Lawson v. Wellesley Hospital (1977) 15 N.R. 271 (S.C.C.).

non-psychiatric one, the hospital was sued for breach of contract to provide care and protection and alternatively for negligence in permitting a mentally ill patient with a propensity for violence to be at large in the hospital without control or supervision. The Chief Justice of Canada noted that the issue was whether a certain statute had the effect of relieving the hospital of liability for its own breach of duty⁸ "whether arising out of contract or in tort."

Another common allegation is breach of contract in failing to provide proper personnel together with negligence as a consequence of the conduct of an employee for whom the hospital is vicariously liable.⁹

This too is a mixed tort and contract action but the alleged negligence of the hospital is not direct but vicarious.

(a) Breach of Contract

In the past, a hospital's direct liability to the patient was usually founded on the contract between it and the patient. The requirements¹⁰ for a contract were not difficult to find and the issue between the patient and the hospital was most often whether a

8. Id. at 274.

9. Aynsley v. Toronto Gen. Hospital [1972] S.C.R. 435; see also Elver-son v. Doctor's Hospital (1974) 49 D.L.R. (3d) 196; affirmed 65 D.L.R. (3d) 382n (S.C.C.).

10. See supra Chapter 3.

certain service was a term of the contract¹¹ Only rarely was the contract express,¹² it being more common for the patient to enter hospital with no discussion of the terms, which were therefore implied.¹³

Thus if the patient was alleging breach of contract against the hospital, the court looked for a written contract or express terms, or failing these, for implied terms. Factors relevant to finding an implied term include legislation,¹⁴ hospital by-laws¹⁵ and even public expectations¹⁶ as well as the conduct of the parties themselves. Obviously some terms, such as those to provide and organize certain nursing, ward and technical personnel, equipment, and facilities are easily implied¹⁷ while others, such as those to provide medical care and define its scope are not.¹⁸ Apart from the problem of ascertaining terms in certain contracts some of the other difficulties outlined in Chapter III may exist in regard to the contract action not the least of which is the unequal position of the two parties.

11. Abel v. Cooke and Lloydminster and Dist. Hospital Bd. [1938] 1 W.W.R. 49 (Alta C.A.).

12. Lavere v. Smith's Falls Public Hospital (1915) 26 D.L.R. 346 (Ont. C.A.).

13. Nyberg v. Provost [1927] S.C.R. 226.

14. Lawson v. Wellesley Hospital supra n. 7.

15. Fraser v. Vancouver Gen. Hospital [1952] 2. S.C.R. 36.

16. Aynsley v. Toronto Gen. Hospital supra n. 9.

17. See Rozovsky, Canadian Hospital Law 14 (1974).

18. See Hôpital Notre Dame de l'Espérance v. Laurent (1978) 3 C.C.L.T. 109 (S.C.C.).

Whatever the reasons, the courts seem to be most reluctant to subject the hospital-patient relationship to a thorough, conclusive contractual analysis.¹⁹ Thus, while it is not uncommon for a patient to plead breach of contract or for a court to note the provision of a certain service as a term of the contract most cases against hospitals now proceed on the basis of negligence.²⁰

(b) Negligence

Negligence as a basis for liability has been thoroughly analyzed in Chapters V and VI. As in the case with the doctor, the duty of the hospital arises upon the formation of the hospital-patient relationship and therefore the issue in negligence cases brought against hospitals is generally the scope of a duty rather than its existence.²¹ Just as in any negligence action, the patient must prove the duty owed to him, the breach of the requisite standard of care and his injury. He must also show that the hospital's conduct was the cause-in-fact and proximate cause of his injury.²²

19. Magnet, Liability of a Hospital for the Negligent Acts of Professionals (1978) 3. C.C.L.T. 135.

20. Keith, Claims Arising out of the Relationship Between Hospital and Patient [1963] L.S.U.C. Spec. Lec. 203.

21. See Cassidy v. Ministry of Health [1951] 1 All E.R. 574 at 585 (C.A.).

22. See Child v. Vancouver Gen. Hospital [1970] S.C.R. 477 where this issue is discussed in regard to the hospital's vicarious liability for the negligence of a nurse.

The duties owed by a particular hospital to a specific patient must be ascertained in each particular case but it is possible to set out and discuss some of the most common ones.²³

It must be remembered that those responsibilities characterized as duties in a negligence action would be labelled terms of the contract in a contract action.²⁴ The standard of care and skill which the hospital must meet is the same in either case.²⁵

(c) Responsibilities

(i) Personnel

A. Selection

Historically, the hospital's first duty to the patient was to select competent staff because it held itself out as being a place where patients would be attended by skilled persons. This responsibility was very narrowly interpreted for many years so that the hospital had only to ascertain that the professional employees such as nurses were qualified and competent and otherwise had no responsibility for their

23. See, for example, Nathan, Medical Negligence 94-104 (1957).

24. See Rozovsky, supra n. 17 at 14 and 52-54; Meredith, Malpractice Liability of Doctors and Hospitals 120-21 (1957).

25. Bernier v. Sisters of Service [1948] 1 W.W.R. 113 (Alta. S.C.).

negligence as professionals.²⁶ The responsibility has been broadened in Canada²⁷ so that a hospital may be vicariously liable for employees even if they are professionals. In 1974 one authority²⁸ pointed out the potential for further expansion of the hospital's liability to include that for the negligence of a doctor who was not an employee, the basis being that the hospital granted privileges to him to admit patients when it knew or ought to have known that he was not qualified or competent, and introduced him to the patient, for example when a patient is seen in the emergency department by a doctor who is an independent contractor but is on call there or on an emergency roster. In a very recent decision²⁹ the prediction came true and with it an apparent commitment to follow American jurisprudence.³⁰ This recent development aside, in regard to doctors who are not employees the obligations of the hospital has been to ascertain that they are qualified and competent³¹ and no more. Thus the earliest and still a basic

26. See, for example, Abel v. Cooke and Lloydminster and Dist. Hospital Bd. *supra* n. 11. For an analysis of the change see *infra* s. 3.

27. Sisters of St. Joseph of the Diocese of London v. Fleming [1938] S.C.R. 172.

28. Rozovsky, *supra* n. 17 at 53.

29. Yepremian v. Scarborough Gen. Hospital (1978) 6 C.C.L.T. 81 (Ont. H.C.). See discussion of this case *infra* s.3.

30. Darling v. Charleston Community Hospital (1965) 211 N.E. 2d 253 (Ill. C.A.).

31. As to the granting of privileges see Rozovsky, *supra* n. 17 at 57; see also Gorback v. Ting [1974] 5 W.W.R. 606 at 607 (Man. Q.B.).

and non-delegable duty³² of the hospital is to ensure that those who treat patients are qualified and competent.

B. Instruction and supervision

Related to the duty of selection and personnel is the duty to ensure that each person is working within his competence. In an Ontario case³³ a hospital was held liable for the injury suffered by a patient when an intern in giving an intravenous injection severed the catheter leaving over nine inches of it in the patient's vein. The Court said that the hospital had a duty to the patient to provide instruction, direction, and supervision to its staff in the use of the Intracath unit, and not having met this standard of care, was negligent. Similarly, an English case³⁴ held a hospital negligent in leaving the administration of a dangerous anaesthetic to an inexperienced doctor without adequate supervision. Assuring adequate instruction and supervision of hospital staff is an enormous responsibility for a hospital necessitating job descriptions, training programs, testing and screening procedures, evaluations, and systems for supervision. The description and assessment of these is beyond the scope of this thesis, but clearly a hospital must have such programs,

32. Kolesar v. Jeffries (1974) 59 D.L.R. (3d) 367 at 376; affirmed (sub nom. Joseph Brant Memorial Hospital v. Koziol) 2 C.C.L.T. 170 (S.C.C.).

33. Murphy v. St. Catharines Gen. Hospital (1963) 41 D.L.R. (2d) 697 (Ont. H.C.).

34. Jones v. Manchester Corpn. [1952] 2 All E.R. 125 (C.A.).

including special provision for the instruction and supervision of student professionals and employees-in-training.

(ii) Organization

A hospital has the responsibility for establishing such systems as are required for the co-ordination of personnel, facilities and equipment so that the patient receives reasonable care. In actions for negligence based on failures in this area, the defence of approved practice has been significant.³⁵ Certain specific areas of the hospital and of patient care can be identified as having given rise to problems, and will now be discussed.

A. The emergency department

Emergency departments of large hospitals, apart from their important role as true emergency centres, to substitute for the house-call may also function as consultation centres where a patient whose symptoms may not indicate a serious condition can be seen and diagnosed by his doctor or by house-staff who report to the doctor. It is not possible to generalize with any certainty about the duty owed by a hospital to a patient to provide him with care in an emergency department. While in some circumstances no duty may exist,³⁶ there are

35. See supra Chapter 6.

36. There may be a statutory duty, see Public Hospitals Act, R.S.O. 1970, c. 378, s. 17 [re-en. 1972, c. 90, s. 11].

factors which are important to weigh in these cases. Public expectations that medical care can be obtained at any emergency department, the government funding of hospitals and the possible creation of a patient-hospital relationship by virtue of the hospital taking even a minor step toward the patient's care all tend to favour the existence of a duty.³⁷ Once present, of course, the hospital must meet a standard of reasonable care by providing competent personnel and proper facilities and equipment; in most cases the hospital's liability results from an employee's negligence rather than from the corporation's negligence.

A few cases are worth noting on these points. In an English case³⁸ the plaintiff was one of the three night-watchmen who became ill after drinking tea and presented themselves at the emergency department of a hospital. A nurse interviewed him briefly, telephoned the doctor on call, and relayed the doctor's message that the patient should go home to bed and call his own doctor. The man died of poisoning within hours. The court, noting that there was no other case to give it guidance, addressed the issue of whether there was a duty on those who provide and run an emergency department "when a person presents himself at that department complaining of illness or injury and before he is treated and received into the hospital wards."³⁹

37. Yepremian v. Scarborough Gen. Hospital *supra* n. 29; see also Hôpital Notre Dame de l'Espérance v. Laurent [1974] C.A. 543 which found the hospital liable; reversed [1978] 1 S.C.R. 605. For a comment see Magnet; *supra* n. 19.

38. Barnett v. Chelsea and Kensington Hospital [1969] 1 Q.B. 428.

39. *Id.* at 436.

The judged noted that the department was open, that the night-watchman entered without hindrance, complained to the nurse who passed this on to a doctor, and advice was given by the doctor. He said:⁴⁰

In my judgment, there was here such a close and direct relationship between the hospital and the watchmen that there was imposed upon the hospital a duty of care which they owed to the watchmen.

As discussed in this case, the standard of care to be met depends upon the facts of the case. Here, the hospital was found negligent by failing to examine, admit and treat the patient but there was no liability because had they done so no treatment could have been provided in time to save the man's life: the hospital's actions were not the cause-in-fact of the patient's death. In the absence of any Canadian authority, this case would be persuasive here for the founding of a duty in similar circumstances. In a recent Canadian case,⁴¹ a mother brought her sick child to a hospital on two consecutive days and although the child was examined she was not admitted on either occasion and, it appears, was suffering from acute appendicitis. Eventually she was admitted to another hospital and underwent surgery but became a spastic quadriplegic. The action was barred by a limitation period but a hospital report indicated that a closer observation and monitoring of systems should have been carried out. In a case from British Columbia,⁴² the

40. Id.

41. Mumford v. Children's Hospital of Winnipeg [1977] 1 W.W.R. 666 (Man. C.A.).

42. Thompson v. Toorenburgh (1973) 50 D.L.R. (3d) 717 (B.C.C.A.).

treatment received by an accident victim in an emergency department was held to be harmful. The patient was suffering from undiagnosed acute pulmonary edema and the procedures used to treat her were incorrect and may have hastened her death. It was held, however, that the motor vehicle accident had caused the pulmonary edema and the actions of the hospital were not a novus actus interveniens,⁴³ notwithstanding that it was indicated by the evidence that the patient would have recovered if proper treatment had been given in the emergency department.

The cases show that a duty of care to the patient is not difficult to find, and the hospital, like the doctor, will not be found liable where it has met the standard of care or where it cannot be proven that it was the cause of the patient's injuries.

The problem of obtaining proper consents to treatment is a very real one for emergency departments. Although a hospital may have an extremely efficient system for having the consent form signed the consent must fulfill the legal requirements outlined earlier.⁴⁴

B. The recovery room

Whereas the emergency department by its very nature may seem to be an area of high potential liability for a hospital, the recovery room may in fact hold more risks. The importance of constant monitoring and observation of the patient in a post-anaesthetic state requires the

43. See supra Chapter 5.

44. See supra Chapter 6.

hospital to organize personnel and facilities accordingly.⁴⁵ Moreover, the injuries to the patient caused by a failure to meet the high standard of care required are usually extreme. Two cases have been reported in Canada in recent times. In the first case⁴⁶ a nurse left to monitor five patients⁴⁷ while the other nurse went for coffee also had to deal with an immediate order to obtain and inject a narcotic drug and a personal telephone call. During the time these events were taking place the patient was left unobserved and developed breathing difficulties which caused brain damage, and was rendered permanently and totally disabled. The trial judge stated that a high standard of care was expected of both hospital and nurses because the recovery room, as the most important room in the hospital, was the one where the patient required the greatest protection from known and ever-present risks. While he was critical of the "lackadaisical attitude" regarding coffee breaks and the failure of the hospital to correct and control the situation he held the hospital to have met the necessary standard of care by providing two registered nurses for the room who were supposed to take coffee breaks before any patients arrived. However, the first nurse was held negligent for leaving the room, and the second nurse for agreeing to this situation, failing to care properly for the patient, and failing to get relief help. Because the nurses were employees and were acting within the scope of their employment the

45. Bernier v. Sisters of Service *supra* n. 25.

46. Laidlaw v. Lions Gate Hospital (1969) 70 W.W.R. 727 (B.C.S.C.).

47. The recommended ratio was one nurse to three patients.

hospital was held vicariously liable.

The result was the same in the second case⁴⁸ where a young boy suffered a respiratory arrest followed by a cardiac arrest and eventually died. In reference to allegations made against the hospital regarding scheduling and organization, the trial judge questioned whether these would be matters of direct or vicarious liability. In the result the hospital was found vicariously liable for the negligence of the five assigned recovery room nurses who failed to observe the patient for 20 - 28 minutes and three of whom went for coffee at the busiest time of the day. The evidence of each of these cases indicates that the proper systems were established by the hospital, but that they were not adequately monitored. While the courts found it easier to require the hospital to compensate the patient on the basis of vicarious liability, both cases point out a breakdown in organization which, it is suggested, was as much the duty of the hospital to monitor as it was the duty of any individual employee to follow.

C. Handling of drugs

The hospital has a duty to set up systems for the efficient and safe handling of drugs.⁴⁹ As in the case of the recovery room, the hospital's liability for drug related problems has usually been vicarious rather than direct,⁵⁰ but injury to a patient through human

48. Krujelis v. Esdale [1972] 2 W.W.R. 495 (B.C.S.C.).

49. Meredith, supra n. 24 at 121.

50. See supra Chapter 5 at 73.

error in obtaining or administering a drug may point out the need for a review of the hospital's system for handling drugs.⁵¹

D. Communication of infection

The hospital has a duty to protect patients from infection⁵² and a duty not to discharge a patient whom it knows or ought to know is infectious.⁵³ The responsibility for assuring that aseptic procedures are followed is also basic to the hospital.⁵⁴

E. Patient surveillance

The hospital may in some cases have a duty to establish procedures to prevent the patient from injuring himself. In a number of cases a patient has leapt from a hospital window and later sued the hospital alleging that there was a duty to provide surveillance and safeguards. In the sole case⁵⁵ in which liability was found against the hospital, the patient was a psychiatric patient with suicidal tendencies who fell

51. Bugden v. Harbour View Hospital [1947] 2 D.L.R. 338 (N.S. S.C.)

52. McDaniel v. Vancouver Gen. Hospital [1934] 4 D.L.R. 593, (P.C.); see supra Chapter 6 for a discussion of this case; see also Lindsey County Council v. Marshall [1936] 2 All E.R. 1076 (H.L.).

53. Evans v. Liverpool Corpn. [1906] 1 K.B. 160; see also Nathan, supra n. 23 at 103.

54. Voller v. Portsmouth Corpn. (1947) 203 L.T.J. 264 (K.B.); see also Meredith, supra n. 24 at 122.

55. Villemure v. Turcot [1973] S.C.R. 716.

to his death from a hospital window. He had been transferred to a semi-private room from the psychiatric ward and, according to the evidence, was recognized as being a "patient to be watched." The majority of the Supreme Court of Canada wrote no judgment in this important case but adopted that of the dissenting member of the Court of Appeal. The hospital's liability seems to have been both direct and vicarious and it is unfortunate that the Supreme Court of Canada did not take this opportunity to clarify some of the issues in this important area. In another case⁵⁶ that went to the Supreme Court of Canada, the Court held that the neurological patient's sudden leap through the window was not foreseeable and could only have been avoided by taking extreme precautions such as using a restraining device or putting the patient at ground level. However the lower courts⁵⁷ had held that the hospital was negligent by failing to provide constant supervision of this patient who was suffering from "epilepsy with post-epileptic automatism" and whose "tendency to irresponsible moving about was well known to all concerned".⁵⁸ In the third case⁵⁹ to go to our highest court the plaintiff was a surgical patient who following abdominal surgery became confused, disturbed and suffered from vivid hallucinations. The hospital assigned three special nurses to care for the patient on eight-hour shifts, but during one of the nurse's coffee

56. University Hospital Bd. v. Lepine [1966] S.C.R. 561.

57. (1965) 53 W.W.R. 513; which varied 50 W.W.R. 709 (Alta. C.A.).

58. University Hospital Board v. Lepine *supra* n. 56 at 570 quoting Farthing J. at trial.

59. Child v. Vancouver Gen. Hospital *supra* n. 22.

breaks he went through a window. All parties to the action agreed that there was no direct liability upon the hospital because the procedures and treatment it had set up for the patient's care met the standard of care expected. Furthermore there was no vicarious liability found because the risk of the patient's doing what he did was not foreseeable to the nurse.

In three other cases⁶⁰ the hospitals were also exonerated on the basis that the patient's self-inflicted injury was not a foreseeable risk. In all cases where no liability was found the court accepted evidence that there was no sign that the patient needed special surveillance or that the patient was a danger to himself.

Thus, it would seem that the duty to supervise a patient will arise when the hospital knows or ought to know of the risk of self-injury. However, the hospital is not an insurer against all hazards and will not be liable if the event in which the patient is injured was not one a reasonable man would have foreseen.

A related question was raised by some very interesting litigation involving a psychiatric hospital.⁶¹ A non-psychiatric patient was injured by a psychiatric patient whose propensity for violence was known to the hospital. The issue at all levels was whether a statute⁶² purporting to exempt the hospital for a tort of a patient

60. Stadel v. Albertson [1954] 2 D.L.R. 328 (Sask. C.A.); Flynn v. Hamilton and Governors of Hamilton City Hospital [1950] O.W.N. 224 (C.A.); Brandeis v. Weldon (1916) 27 D.L.R. 235 (B.C. C.A.).

61. Lawson v. Wellesley Hospital *supra* n. 7.

62. Mental Health Act, R.S.O. 1970, c. 269, s. 59.

was effective to bar the action against the hospital. The Supreme Court of Canada held that the section had no application to protect the hospital against its own direct negligence and the case could proceed to trial.⁶³ Under common law a hospital was not vicariously liable for the torts of patients, thus the basis for any liability in such a fact situation would have to be based on direct liability, that is, a failure to meet the standard of care in carrying out the duty to provide the organization necessary so that the patient receives reasonable care. Put simply, a hospital may be liable directly for negligence in failing to provide adequate supervision of patients. In future cases the main issue will be what standard of care is reasonable in the circumstances.⁶⁴

(iii) Facilities and equipment⁶⁵

A hospital is under a duty to provide proper facilities and equipment and to maintain them.⁶⁶ To meet the standard of care a hospital

63. The case is not reported as having gone to trial and was, no doubt, settled out of court.

64. For an excellent discussion of the case see Brandt, Liability of Custodial Institutions for Torts of Patient Inmates (1977) 1 Leg. Med. Q. 193; see also Sharpe, Hospital Responsibility for Acts of Patients (1976) 4 Chitty's L.J. 140; Sharpe Mental State as Affecting Liability in Tort (1975) 23 Chitty's L. J. 46.

65. For a detailed discussion of this topic see supra Chapter 5 at s. 2. (b) (ii) C.

66. Cahoon v. Edmonton Hospital Bd. (1957) 23 W.W.R. 131 (Alta. S.C.); Abel v. Cooke and Lloydminster and Dist. Hospital Bd. supra n. 11; see also Meredith, supra n. 24.

need not have the latest and best facilities and equipment but it cannot ignore those which have found their way into common use. Furthermore, there is a clear statement in a case against a hospital that locality is not a justification for a lower standard of care in a rural hospital.⁶⁷ There have been a number of cases in which hospitals have been sued for a failure to provide bed rails with the result that a patient has fallen from his bed suffering injuries, but in no case have the courts found liability. In two cases it was held that such equipment posed a physical⁶⁸ or psychological⁶⁹ risk to the patient, and in another,⁷⁰ in which a young man fell onto a hot radiator, it was important that unenclosed radiators were in "all older type hospital buildings." The defence of approved practice was also important in another case⁷¹ where the court observed that hospital authorities cannot be influenced by the request of every patient or anxious relative for specific facilities or equipment. The defence of approved practice has proven to be a most effective one throughout the

67. Bernier v. Sisters of Service *supra* n. 25.

68. Robinson v. Annapolis Gen. Hospital (1956) 4 D.L.R. (2d) 421 (N.S.S.C.).

69. McKay v. Royal Inland Hospital (1964) 48 D.L.R. (2d) 665 (B.C. S.C.).

70. Cahoon v. Edmonton Hospital Bd. *supra* n. 66.

71. Florence v. Les Soeurs de Misericorde (1962) 39 W.W.R. 201 (Man. C.A.); see also Hôtel Dieu de Montréal v. Couloume [1975] 2 S.C.R. 115 (S.C.C.) where there was held to be no liability when a patient fell from his bed during an epileptic seizure. But see Beatty v. Sisters of Misericorde of Alberta [1935] 1 W.W.R. 651 (Alta. S.C.) where there was vicarious liability when a sedated patient fell from her bed.

cases dealing with the hospital's direct liability.

In three very similar cases⁷² young children suffered serious burns from equipment set up for steam inhalation. In each the hospital was held liable not for the equipment itself but for a failure to supervise the use of such equipment near infant patients. Hospitals have a responsibility to see that the use of equipment is in competent hands and, if necessary, to provide instruction as to its proper use.⁷³

Hospitals do not, however, have a responsibility to "employ overseers to ensure that anaesthetists or surgeons of proved ability who are privately engaged use the appliances which the hospital has at hand."⁷⁴

As an occupier and perhaps owner of premises, a hospital has certain duties to persons on those premises. The topic of occupiers' liability is beyond the scope of this thesis,⁷⁵ but it is worth noting that this field is now covered by legislation in some provinces.⁷⁶

72. Shaw v. Swift Current Union Hospital Bd. [1950] 1 W.W.R. 737 (Sask. C.A.); Sinclair v. Victoria Hospital [1943] 1 W.W.R. 30 (Man. C.A.); Harkies v. Lord Dufferin Hospital [1931] 2 D.L.R. 440 (Ont. H.C.).

73. Murphy v. St. Catharines Gen. Hospital *supra* n. 33.

74. Crits v. Sylvester (1956) 1 D.L.R. (2d) 502 at 504; affirmed [1956] S.C.R. 991; see also Anderson v. Chasney [1949] 4 D.L.R. 71 at 87; affirmed [1950] 4 D.L.R. 223 (S.C.C.).

75. See Speller, *supra* n. 1.

76. Occupiers' Liability Act, 1973 (Alta.), c. 79; Occupiers' Liability Act, 1974 (B.C.), c. 60 [am. 1975 c. 14, s. 12].

3. Vicarious Liability

The most common basis upon which a hospital must compensate a patient for the damage he has suffered is vicarious liability, described in the preceding chapter.⁷⁷ Put briefly, an employer is liable for the torts of an employee committed within the scope of his employment but is generally not liable for those of an independent contractor.

Because vestiges of past jurisprudence continue to influence modern law⁷⁸ on this topic it is necessary to review rather briefly the growth of the hospital's vicarious liability for professionals such as doctors and nurses.⁷⁹ The early authorities were English cases but they influenced our courts for many years.⁸⁰

In 1906 an English⁸¹ court held that a hospital was not vicariously liable for the negligence of a doctor who was an employee because it did not have control over him in his professional activities. Similarly, in a famous English case, Hillyer v. St. Bartholomew's Hospital,⁸² the court held that a hospital's responsibilities were

77. See supra Chapter 9.

78. See discussion of "borrowed servant".

79. See Fleming, Developments in the English Law of Medical Liability (1959) Vand. L. Rev. 633. As for Canada see Linden, Changing Patterns of Hospital Liability in Canada (1966-67) 5 Alta. L. Rev. 212.

80. See Rozovsky, The Hospital's Responsibility for Quality of Care Under English Common Law (1976) 4 Chitty's L.J. 132.

81. Evans v. Liverpool Corporation supra n. 53.

82. [1909] 2 K.B. 820 (C.A.).

to ensure that the persons giving medical care were competent and had proper apparatus and appliances. It would be vicariously liable for negligent acts of professionals while exercising their "ministerial or administrative duties", but not while they were carrying out professional duties, the reason for the distinction being the perceived absence of control of the employer over those professional activities. It is worth noting that it was also held that in any case at the critical time the nurses were under the control of the operating surgeon. This obiter comment lives on seemingly full of potential never realized.⁸³

Thus, a hospital was for many years not liable for doctor-employees nor for the negligence of nurse-employees committed in carrying out their professional duties. Its main responsibility was to select personnel carefully. Eventually, however, in 1942 in Gold v. Essex County Council⁸⁴ this strange split in responsibility was discarded as being "unworkable and contrary to common sense." The negligence involved was that of a radiology technician but the position was held to be the same as that of the nurse. Whatever confusion remained was removed in Cassidy v. Ministry of Health⁸⁵ where the hospital was held liable for the negligence of a house surgeon employed as part of the permanent staff. The Hillyer decision was reviewed and restricted to its facts.

83. See Rozovsky, supra n. 17 at 19.

84. [1942] 2 K.B. 293 (C.A.); see also Logan v. Waitaki Hospital Bd. [1935] N.Z.L.R. 385 (S.C.).

85. [1951] 1 All E.R. 574 (C.A.).

Denning L.J. said:⁸⁶

Relieved thus of Hillyer's case, this court is free to consider the question on principle, and this leads inexonerably to the result that, when hospital authorities undertake to treat a patient and themselves select and appoint and employ the professional men and women who are to give the treatment, they are responsible for the negligence of those persons in failing to give proper treatment, no matter whether they are doctors, surgeons, nurses, or anyone else. Once hospital authorities are held responsible for the nurses and radiographers, as they have been in Gold's case, I can see no possible reason why they should not also be responsible for house surgeons and resident medical officers on their permanent staff.

Denning L.J. pointed out that it is employers who choose and can dismiss employees and this power is the reason that they should be held vicariously liable even where they cannot for various reasons control the employee.⁸⁷ Furthermore, the old control test had become somewhat of an anachronism and it was apparent that one of the policy reasons for restricting the liability of hospitals, that of protecting the privately supported or charity hospital, was no longer present, state-supported hospitals becoming more common. Thus the questions became whether the person's work was an integral part of the hospital organization and whether the patient employed him.⁸⁸ As will be seen the last question may have come to be paramount.⁸⁹ In the last

86. Id. at 586.

87. See Rozovsky, supra n. 80 at 133 where the author notes that hospitals have this same power of sanction over independent contractor doctors who have been granted privileges.

88. Fleming, The Law of Torts 361 (5th ed. 1977); see also Goodhart, Hospitals and Trained Nurses (1938) 54 L.Q. Rev. 553.

89. See discussion of the case of Yepremian v. Scarborough Gen. Hospital infra.

English case in the chain, Roe v. Minister of Health,⁹⁰ the English Court of Appeal went a step further by holding that a hospital would be liable for a part-time anaesthetist employed and paid by the hospital as a member of the permanent staff but who also carried on a private practice. The potential of this decision will be discussed later in this chapter.

While Canadian courts did follow the Hillyer's decision⁹¹ it was not applied consistently and was restricted as early as 1916 by an Ontario court⁹² which said it should not be taken as an exposition of the whole law. In an important decision in 1938, Sisters' of St. Joseph of the Diocese of London v. Fleming⁹³ the Supreme Court of Canada said the ministerial-professional distinction set out in the Hillyer case was entitled to great respect but the Court was not bound to follow it; in any event the negligent action of the nurse in the case was held to be ministerial. There were a number of similar cases⁹⁴ in which courts declared themselves unprepared to espouse the Hillyer principle yet found the conduct from which the negligence arose to be ministerial.

90. [1954] 2 Q.B. 66 (C.A.).

91. Abel v. Cooke and Lloyminster and Dist. Hospital Bd. supra n. 11; Vuchar v. Toronto Gen. Hospital Trustees [1937] O.R. 71 (C.A.).

92. Lavere v. Smith's Falls Public Hospital supra n. 12.

93. Supra n. 27.

94. See, for example, Nyberg v. Provost supra n. 13; see also Linden, supra n. 79 at 215.

Canadian courts rejected the Hillyer principle more strongly with the decision of Fraser v. Vancouver Gen. Hospital⁹⁵ in which the hospital was held liable for the negligence of an intern, and Petite v. McLeod⁹⁶ in which all of the law was reviewed and it was said by the court, obiter, that there was no difference between professional and non-professional acts.

More modern authority has made it clear that there is no bar to a hospital's being found liable for doctors, nurses or other professionals.⁹⁷ Unfortunately no precise test exists to determine when liability will follow; a frequent judicial suggestion is that each case must be examined and dealt with on its own facts.⁹⁸ There are some basic principles, however, which will now be discussed.

(a) Doctors

Whether a hospital will be vicariously liable for the negligence of a doctor depends upon the relationships among the hospital, the doctor and the patient.

95. Supra n. 15.

96. [1955] 1 D.L.R. 147 (N.S. S.C.). Note that it was found that the doctor was not on the house staff and that the evidence regarding a swab was insufficient rendering the hospital not liable.

97. Aynsley v. Toronto Gen. Hospital supra n. 9.

98. See Toronto Gen. Hospital v. Aynsley (1969) 7 D.L.R. (3d) 193 at 203 (Ont. C.A.); affirmed supra n. 9.

In the great majority of cases,⁹⁹ the patient engages and pays the doctor (usually through medicare plans) and has the power to dismiss him. The hospital does not employ the physician nor is he carrying out any of the hospital's duties to the patient. He is granted the privilege of using personnel, facilities and equipment provided by the hospital but this alone does not make him an employee. He is an independent contractor who is directly liable to his patient for his negligence.

But the relationships may give rise to hospital liability. The clearest situation for vicarious liability is for those doctors employed as house staff (residents or interns).¹⁰⁰ In these situations the employer-employee arrangement is set out in a written contract between the hospital and the doctor. The employer's attempts to control the activities of such house staff are usually evident from manuals and directives issued by the hospital. An alternate basis for the hospital's being held liable for the actions of house staff is that it has a duty to the patient to select only competent, qualified staff.¹⁰¹ The cases in which the negligence of house staff has made the hospital

99. Hôpital Notre Dame de l'Espérance v. Laurent supra n. 18; Tiesmaki v. Wilson [1974] 4 W.W.R. 19; affirmed [1975] 6 W.W.R. 639 (Alta. C.A.); Serre v. de Tilly (1975) 58 D.L.R. (3d) 362 (Ont. H.C.); Johnston v. Wellesley Hospital (1970) 17 D.L.R. (3d) 139 (Ont. H.C.); Petite v. MacLeod supra n. 96; Yepremian v. Scarborough Gen. Hospital supra n. 29.

100. Aynsley v. Toronto Gen. Hospital supra n. 9; Fraser v. Vancouver Gen. Hospital supra n. 15; Karderas v. Clow (1973) 32 D.L.R. (3d) 303 (Ont. H.C.); Murphy v. St. Catharines Gen. Hospital supra n. 33; Cox v. Saskatoon [1942] 1 W.W.R. 717 (Sask. C.A.); Beatty v. Sisters of Misericorde of Alberta supra n. 71.

101. Murphy v. St. Catharines General Hospital supra n. 33.

vicariously liable were discussed earlier.¹⁰²

There are doctors whose relationship to the hospital does not fit into either of the personal doctor-independent contractor or house staff-employee categories, and in these cases the facts must be carefully analyzed.¹⁰³ A number of cases outlined in Chapter V dealt with the negligence of anaesthetists.¹⁰⁴ In some of those cases the hospital was vicariously liable and in some it was not. For example, in Martel v. Hôtel-Dieu St-Vallier¹⁰⁵ it was found that the anaesthetist was a salaried employee of the hospital also receiving a portion of the fees for service charged by the hospital. The patient did not choose him, as anaesthesia services were provided by the hospital and assignments were made by the head of anaesthesia. The court said:¹⁰⁶

The anaesthetist in this case gave his services as he was obliged to do under his contract of employment with the hospital, as did the other members of the staff: radiologists, laboratory technicians, hospital attendances, nurses, etc. The fact that he was a specialist changes nothing. It would be contrary to the evidence, to consider the hospital as a mandatary which had ordered professional anaesthesia services for the plaintiff. This is not what happened.

102. Supra Chapter 5.

103. Cassidy v. Ministry of Health supra n. 85.

104. Supra Chapter 5.

105. (1969) 14 D.L.R. (3d) 445 (S.C.C.). Note that the doctor was referred to as a "resident anaesthetist" but because he had his specialist certificate, it was indicated that he was not characterized as a resident-housestaff-doctor.

106. Id. at 451.

In another case, the Quebec Court of Appeal identified similar factors:¹⁰⁷

It is established that Dr. Forest was employed by the hospital as chief anaesthetist and despite the efforts made to show that the salary paid him was for services rendered in a special and restricted field I am satisfied that he was held out to plaintiff as the Hospital's anaesthetist, that he acted in this capacity and that plaintiff accepted him because of this. In this case the patient contracted with the Hospital for all necessary services; of these one was giving of the anaesthetic. On this premise and since for the purposes of this action I see no essential difference between the position of Dr. Forest and that of any other employee, the hospital must answer for his fault.

In an important English case referred to earlier, Roe v. Minister of Health,¹⁰⁸ two anaesthetists provided anaesthetic coverage for a hospital. They were paid from a fund set up for all medical and surgical staff (including visiting and consulting doctors) and could carry on private anaesthetic practices as well. While the trial judge held the hospital's obligation to be limited to providing competent anaesthetists,¹⁰⁹ the Court of Appeal held the hospital to be vicariously liable. One judge considered it to be a matter of law that in all cases a hospital undertakes a duty of care in regard to all care and treatment provided by the staff it has selected, employed, and paid¹¹⁰ while another preferred to leave it that a hospital's

107. Beausoleil v. La Communauté des Soeurs de la Charité (1966) 53 D.L.R. (2d) 65, [1965] Q.B. 37 at 43 (Que. C.A.)

108. Supra n. 90.

109. Id. at 69.

110. Id. at 82 per Lord Denning.

obligations can only be decided by considering the circumstances of each particular case.¹¹¹ The latter approach is the one favoured by Canadian courts,¹¹² but the former raises the possibility that the hospital has a direct responsibility to a patient which goes beyond ensuring the competence of medical personnel.¹¹³

In other Canadian cases hospitals have not been vicariously liable for negligent anaesthetists. The important facts in those cases were that the doctors were retained by the patients¹¹⁴ on a direct contractual fee-for-service basis with no remuneration from the hospital.¹¹⁵

An Australian case held a hospital liable for the negligence of an outside radiologist to whom, in the absence of its employee-radiologist, it had referred x-rays. The hospital had undertaken to provide the patient with diagnostic x-ray services and was held liable when this was negligently done, albeit by a non-employee.

In summary there are some factors which can be identified as being common in those cases where a hospital has been found liable for a doctor's negligence. The patient has generally not chosen the doctor; he has been provided by the hospital as part of certain services.

111. Id. at 88 per Lord Justice Morris.

112. Aynsley v. Toronto Gen. Hospital supra n. 9.

113. See infra the discussion of the Yepremian case.

114. This was the situation with the anaesthetists in Aynsley v. Toronto Gen. Hospital supra n. 9 and in Crits v. Sylvester [1956] S.C.R. 991.

115. Gorback v. Ting supra n. 31.

There may be a public expectation that such a doctor or service will be provided by the hospital.¹¹⁶ There is an absence of control by the patient, usually stemming from the fact that the patient was not the one who engaged the doctor. Also, the doctor may well be described as being an integral part of the hospital organization rather than an accessory to it. Most obvious, but not necessarily most important, a stipend or salary received from the hospital is often a factor.

Most of the above factors were present in the very recent and important decision of Holland J. in the Ontario Supreme Court.¹¹⁷ The patient was a 19 year old man whose first symptoms were increased frequency of urination and fluid intake but who within hours was hyperventilating and then semi-comatose. Within 35 hours of being treated by the first of three doctors and being through the emergency department and intensive care unit of a hospital he suffered a cardiac arrest with consequential serious brain damage, the cause of which was found to be the negligence of an internist, Dr. Rosen, to diagnose and then properly treat for diabetes. The diagnosis was eventually made by a nurse and the prescribed medication, sodium bicarbonate and excessive dosages of insulin, caused the patient's potassium level to fall and although potassium was then ordered it was too little and too late. Dr. Rosen was a non-employee, an independent contractor who had hospital privileges and who was the internist on call for emergency. But Dr. Rosen was not sued by the patient Yepremian. Action was

116. Rozovsky, supra n. 80 at 133.

117. Yepremian v. Scarborough Gen. Hospital supra n. 29.

brought against the general practitioner who first saw the patient in his office and diagnosed "tonsillitis" and the general practitioner on duty in emergency who diagnosed "hyperventilation," which is actually a sign, not a diagnosis. The trial judge found that these two doctors were negligent but that their negligence was not the proximate cause of the patient's injuries for it was not foreseeable that the patient would subsequently receive negligent treatment. Further, their negligence was not found to be a contributing cause-in-fact. The hospital was not vicariously liable because its nurses and laboratory technicians had followed both the doctor's orders and the approved practice. The trial judge did an extensive review of the English and Canadian authorities examined earlier in this chapter and noted provisions in the Public Hospitals Act¹¹⁸ requiring a hospital to admit a patient and found there the intention that the hospitals be directly responsible for the quality of care provided. He also referred to and quoted from the landmark American case Darling v. Charleston Community Hospital¹¹⁹ where a hospital was held liable for the negligence of a doctor who was an independent contractor on the basis of a direct corporate liability rather than vicarious liability.

The U.S. court in the Darling case said:¹²⁰

118. Supra n. 36, ss. 17 [re-en. 1972, c. 90, s. 11], 41.

119. Supra n. 30. Note that this case has been widely discussed in the U.S. but not specifically adopted by any other jurisdiction. See Curran and Shapiro, Law, Medicine and Forensic Science 614 (5th ed. 1977).

120. Id. at 257 quoting from another U.S. case Bing v. Thunig (1957) 143 N.E. 2d 3 at 8 (N.Y.C.A.).

The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility, no longer reflects the fact. Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment. They regularly employ on a salary basis a large staff of physicians, nurses and interns, as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting for such services, if necessary, by legal action. Certainly, the person who avails himself of "hospital facilities" expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility.

Holland J. summarized the principles¹²¹ in the case before him and gave judgment:

Except in exceptional circumstances,

1. a hospital is not responsible for negligence of a doctor not employed by the hospital when the doctor was personally retained by the patient;
2. a hospital is liable for the negligence of a doctor employed by the hospital,
3. where a doctor is not an employee of the hospital and is not personally retained by the patient, all of the circumstances must be considered in order to decide whether or not the hospital is under a non-delegable duty of care which imposes liability on the hospital.

The present case falls into the third category. I think the case must be considered from the point of view of the patient, the hospital and the doctor. In so far as this particular patient was concerned, he was semi-comatose on admission. It was not even his decision to go to the hospital; it was the decision of his parents. Tony Yepremian was taken to the hospital because he was obviously serious ill and in need of treatment. The public as a whole, and Tony Yepremian and his parents in particular, looked to the hospital for a complete range of medical attention and treatment. In this case there was no freedom of choice. Tony Yepremian was checked into the Emergency Department by Dr. Chin and not by a doctor of his choice. Dr. Chin was required to work for certain periods of time in the Emergency Department. When Tony Yepremian

121. Yepremian v. Scarborough Gen. Hospital *supra* n. 29 at 38-40.

was admitted to the intensive care department of the hospital he was admitted under the case of Dr. Rosen. Tony Yepremian had no choice in the matter. The fact that Dr. Rosen happened to be the internist at the time of admission was the luck of the draw so far as the Yepremians were concerned. They really, I suppose, had no concern other than an expectation that this hospital would provide not only a room, but everything else that is required to make sure, so far as it possible, that the patient's ailments are diagnosed and that proper treatment is carried out, whether this is done by an employed doctor, a general practitioner or a specialist. From the point of view of the hospital, the hospital, by virtue of the provisions of the Public Hospitals Act above referred to, and as a matter of common sense, has an obligation to provide service to the public and has the opportunity of controlling the quality of medical service. From the point of view of the doctor, through the surrender of some independence by reason of the control that may be exercised over him by the hospital and by making his services available at certain specified times, he attains, by accepting a staff appointment, the privilege of making use of the hospital facilities for his private patients. I have come to the conclusion that in the circumstances of this case by accepting this patient the hospital undertook to him a duty of care that could not be delegated. It may be that the hospital has some right of indemnity against the doctor but that is not before me.

For the above reasons I have come to the conclusion that the hospital is responsible in law for the negligence of Dr. Rosen.

Thus a hospital has been held liable for the negligence of a doctor who was not an employee but an independent contractor.¹²²

The result in this case¹²³ raises some interesting questions. First, will the distinction between employees and independent contractors become unimportant in the hospital context? That is, will the hospital's non-delegable duty of care to a patient to ensure that he receives proper treatment from the staff it provides, now include even those doctors who are primarily independent contractors but whom the

122. (1978), 6 C.C.L.T. 81 (Ont. H.C.). Higher courts may have the opportunity to review this decision.

123. See also Fleming, supra n. 88 at 361-2; Nathan, supra n. 23 at 132.

hospital may be seen as "holding out" as competent? The obvious cases are those of anaesthetists, radiologists and doctors on call for emergency. Second, will the legal basis for such a duty be that it is a true direct responsibility under certain circumstances to provide competent medical treatment or will it be a form of extended vicarious liability wherein the doctor is deemed to be an employee?¹²⁴ If the hospital's liability for doctors continues to expand, will the procedure for granting privileges and the monitoring of standards have to be re-examined?¹²⁵ It will take some time for the answers to emerge but the trend to greater accountability of hospitals to the public for medical treatment seems clear.¹²⁶

124. It might make no difference to the patient who would be compensated either way but it would make a difference to the hospital's and doctor's insurers.

125. See Alberta Hospitals Act, R.S.A. 1970, c. 174; B.C. Reg. 289/73 (1973), ss. 15-28 [am. 1978, c. 19]; Public Hospitals Act, R.S.O. 1970, c. 378, s. 40 [re-en. 1972, c. 90, s. 22], s. 41, ss. 42-50 [en. 1972, c. 90, s. 23; am. 1973, c. 164, s. 1]; Hospital Standards Act, R.S.S. 1965, c. 265, ss. 21-30 [en. 1972, c. 52, s. 3; am 1976-77, c. 31, s. 5].

126. See Rozovsky, supra n. 17 at 15 where it is suggested that it would be wise for hospitals and doctors to have written contracts clearly stating when a doctor is working as an employee and when he is working as an independent contractor. However, a patient with no knowledge of the contract might have different expectations of the doctor and the hospital.

(b) Nurses

A hospital is vicariously liable for negligence committed within the scope of a nurse's employment.¹²⁷ As discussed earlier,¹²⁸ this was not always the case and for that reason cases decided in the first half of the century must be read with caution.

In virtually all hospital-patient relationships today it is an implied term of the contract that the hospital undertakes not only to select competent nurses but also to nurse the patient. Thus it is arguable that this is an alternate basis for the hospital's direct liability.¹²⁹

Since the obiter comment in Hillyer v. St. Bartholomew's Hospital¹³⁰ that a hospital would not be liable for the negligence of nurses or doctors in the operating room, a number of courts¹³¹ and other authorities¹³² have felt compelled to comment on whether a nurse might be viewed in law as ceasing to be the employee of the

127. Joseph Brant Memorial Hospital v. Koziol *supra* n. 32; see also Petite v. MacLeod *supra* n. 96; Sisters of St. Joseph of the Diocese of London v. Fleming *supra* n. 27.

128. Supra.

129. Bernier v. Sisters of Service *supra* n. 25; see also Lavere v. Smith's Falls Public Hospital *supra* n. 12 where the contract was express.

130. Supra n. 82.

131. See, for example, Johnston v. Wellesley Hospital *supra* n. 99; Vuchar v. Toronto Gen. Hospital Trustees *supra* n. 91.

132. Meredith, *supra* n. 24 at 131; Nathan, *supra* n. 23 at 62; Rozovsky, *supra* n. 17 at 19.

hospital and become an employee of a doctor or even the patient. This has been called the borrowed servant rule.¹³³ While the original premises has been destroyed (hospitals can now be held liable for the negligence of employees in the operating room)¹³⁴ the theory has remained that a nurse might in some circumstances become a borrowed servant.¹³⁵ To do so, however, a nurse would have to be so far outside her duties as a nurse that it is not surprising that there are no reported Canadian or English cases where a hospital has been relieved of liability on that basis.¹³⁶

A nurse's duty is to carry out the doctor's orders and he can rely on her to do so.¹³⁷ If she falls below the standard of care expected of her in this regard she will be negligent and the hospital will be vicariously liable. She will also risk being liable if she carries out an order which as a professional she knows or ought to know was improper.¹³⁸

A hospital is not liable for the negligence of a private or special nurse engaged and paid by the patient and carrying out the patient's

133. See Mersey Docks and Harbour Bd. v. Coggins and Griffith [1946] 2 All E.R. 345 (H.L.).

134. Aynsley v. Toronto Gen. Hospital *supra* n. 9; Karderas v. Clow *supra* n. 100; Bugden v. Harbour View Hospital *supra* n. 51.

135. Meredith, *supra* n. 24 at 131.

136. Rozovsky, *supra* n. 17 at 19.

137. Serre v. de Tilley *supra* n. 99; Laidlaw v. Lions Gate Hospital *supra* n. 46 at 738, Lavere v. Smith's Falls Public Hospital *supra* n. 12.

138. Rozovsky, *supra* n. 17 at 19.

duties.¹³⁹ It is liable, of course, if it employs the nurse, as where a patient requires special care.¹⁴⁰ However, a hospital could be exposed to liability from the relationship between the hospital patient and special nurse in some circumstances.¹⁴¹ If the hospital selected or recommended a nurse the patient could argue a duty of care was created. Further, if a hospital knew or ought to have known that a special nurse was acting in a careless or negligent manner toward the patient it is arguable that failure to advise the patient would be a breach of the standard of care owed to him. Finally, if a special nurse was allowed to carry out duties which were normally part of the hospital's undertaking the hospital might be liable. There have been so few Canadian cases that it is impossible to predict the outcome of these theoretical situations with certainty.

A hospital is liable for negligence committed within the scope of a student nurse's employment. In a Saskatchewan case¹⁴² an infant being weighed by a student nurse rolled off the scale onto a hot radiator and the hospital was held vicariously liable. The result was the same in an Ontario case where an infant in the charge of a student nurse was scalded by steam from an inhalation apparatus.¹⁴³ As

139. Tiesmaki v. Wilson *supra* n. 99; *see also* Meredith, *supra* n. 24 at 136.

140. Child v. Vancouver Gen. Hospital *supra* n. 22; Logan v. Colchester [1928] 1 D.L.R. 1129 (N.S.C.S.).

141. *See* Rozovsky, *supra* n. 17 at 20.

142. Farrell v. Regina [1949] 1 W.W.R. 429 (Sask. K.B.).

143. Harkies v. Lord Dufferin Hospital *supra* n. 72.

mentioned with regard to nurses and house staff the basis for liability in such cases may also be a breach of the hospital's responsibility to select and instruct personnel. The hospital has an obvious interest in instructing and supervising students.¹⁴⁴

Certain areas can be identified as giving rise to negligence actions against nurses, for which a hospital will be held liable. There are quite a large number of older cases where patients have suffered burns from hot water bottles, steam inhalators and even x-ray machines.¹⁴⁵ The negligence of nurses in the recovery room has led to extensive liability of hospitals in two remarkably similar modern cases.¹⁴⁶ Liability has followed the administration of the wrong drug¹⁴⁷ or an injection in the wrong location.¹⁴⁸ Allegations related to the failure to report signs of circulatory impairment¹⁴⁹

144. For excellent practical suggestions see Rozovsky, supra n. 17 at 21.

145. Sisters of St. Joseph of the Diocese of London v. Fleming supra n. 27; Nyberg v. Provost supra n. 13; Bernier v. Sisters of Service supra n. 25; Sinclair v. Victoria Hospital supra n. 72; Craig v. Soeurs de Charité de la Providence [1940] 2 W.W.R. 80; affirmed [1940] 3 W.W.R. 336 (Sask. C.A.); Abel v. Cooke and Lloydminster and Dist. Hospital Bd. supra n. 11; Davis v. Colchester [1933] 4 D.L.R. 68 (N.S.S.C.); Shaw v. Swift Current Union Hospital supra n. 72; Eek v. Bd. of High River Mun. Hospital [1926] 1 W.W.R. 36 (Alta. S.C.); Lavere v. Smith's Falls Public Hospital supra n. 12.

146. Supra s. 2(c)(ii) B.

147. Bugden v. Harbour View Hospital supra n. 51; Barker v. Lockhart [1940] 3 D.L.R. 427 (N.B.C.A.); see also supra Chapter 5.

148. Huber v. Burnaby Gen. Hospital [1973] D.R.S. 653 (B.C.S.C.); Laughlin v. Royal Columbian Hospital [1971] D.R.S. 694 (B.C.C.A.); see also Cavan v. Wilcox (1974) 2 N.R. 618, 50 D.L.R. (3d) 687; reversing 44 D.L.R. (3d) 42 S.C.C.

149. See, for example, Vail v. MacDonald (1976) 66 D.L.R. (3d) 530 (S.C.C.).

or to observe patients who injure themselves¹⁵⁰ have not generally been successful. One of the more extreme cases of negligent nursing appears in the case of Joseph Brant Memorial Hospital v. Kozoil. The patient had had back surgery and was placed in a Stryker frame. Some seventeen hours after being placed on the ward he died of "pulmonary edema and haemorrhage secondary...to the aspiration of gastric juice. His bladder was grossly distended".¹⁵¹ His death was held to have been caused by negligent nursing care in that he was not roused to cough and breathe deeply, or to perform simple body movements. He was given large quantities of fluids and his blood pressure, respiration, pulse and temperature were not taken nor recorded properly. The medical record was not properly kept. In general, care was found to be below the standard expected of a professional nurse and the hospital was vicariously liable.

(c) Other Employees

The hospital is liable for the negligence of all of its employees within the scope of their employment.¹⁵²

150. See supra ss. 2(c)(ii) E. and (c)(iii).

151. (1977) 2 C.C.L.T. 170 (S.C.C.).

152. See, for example, Wyndham v. Toronto Gen. Hospital Trustees [1938] O.W.N. 55 (Ont. H.C.) wherein a ward-aide was found negligent; Mckay v. Royal Inland Hospital supra n. 69 wherein a physio-therapist was found not negligent.

(d) Volunteers

There are no reported Canadian cases where a volunteer has injured a patient and put the position of the hospital in issue. However, the hospital could be held either directly or vicariously liable within the principles outlined in this chapter and thus care and planning is required when allowing volunteers into the hospital.¹⁵³

In summary, the responsibilities of the hospital to the patient have expanded greatly in breadth and depth in this century.¹⁵⁴ Hospitals have become much more than the hotel-employment agency they once were but with their greater size and sophistication has come an impersonal approach often aggravated by poor public relations. Public attitudes to hospitals have changed partially the consequence of the removal of barriers to liability but largely due to the apparent means of hospitals, through government funding, to compensate. Public expectations that hospitals will provide total care and make all arrangements are influencing courts in determining the responsibilities of hospitals. If the hospital is to bear more responsibility for the doctor, present systems and organization may have to be reviewed. It is clear that the doctor-hospital relationship has never been more important and it must be improved.

153. See Rozovsky, *supra* n. 17 at 24 for suggestions.

154. See Fleming, *supra* n. 79 at 638.

In the search for roles, relationships and responsibilities a basic principle should be kept in sight: compensation will only be required to be paid to patients who have suffered a legal wrong.

CHAPTER XI

CONCLUSION

1. Common Concerns

(a) A "malpractice crisis" in Canada.

Concern has been expressed that because a "malpractice crisis" is rampant in the United States and because there may be "no effective quarantine along the world's longest undefended border"¹, Canada will be struck by the malady. Rozovsky² has said about this fear in Canada:

The fear of such a crisis already exists in this country on the theory that what happens in the United States eventually takes place in Canada. This fear has led to irresponsible and uninformed public statements, unnecessary and sometimes foolish administrative action and misguided legislative enactments.

Thus, while it seems important to assess the Canadian situation one is hampered in doing so by a dearth of reliable statistical data. Indeed the only source of information on legal actions brought against doctors and hospitals is the Canadian Medical Protective Association's Annual Reports which cover only member doctors. Canadian hospitals are

1. Geekie, The Crisis in Medical Malpractice: Will it Spread to Canada (1975) 113 Can. Med. Ass'n. J. 327.

2. Rozovsky, Medical Malpractice in Canada (1977) 1 Leg. Med. Q. 2.

insured through private companies and no national statistics on claims are available.³ Also, there are very few empirical studies to measure the attitudes and practices, and the knowledge of the law of patients and health care professionals in Canada.

While any opinion on the likelihood of a "malpractice crisis" developing in Canada is not as reliable as it could be if more information was available,⁴ there is some help at hand. There are many descriptions of the United States "malpractice crisis" and excellent analyses of the factors responsible for its growth.⁵ We also have Canadian authorities prepared to contrast and assess them with the situation in our own country.⁶

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3. Id. at 3; see Kendrick, Malpractice - The Insurance Problem in Canadian Hospital Association Papers and Proceedings of the National Conference on Health and the Law 66 (1975) where a few figures are available.
 4. A good example is the opinions on the effect of the contingent fee which range from seeing it as a factor in a possible Canadian crisis to seeing it as assisting in maintaining the competence of doctors. Yet beyond knowing the provinces in which it can be arranged (B.C., Alta., Sask., N.B., N.S., Que.), we know nothing about the use of the contingent fee in Canada in medical negligence cases.
 5. See, for example, Bernzweig, Malpractice - The Situation in the U.S. in Canadian Hospital Association Papers and Proceedings of the National Conference on Health and the Law 26 (1975); see Rozovsky, supra n. 2 for a description of the Commission on Medical Malpractice and the Rikecoff Report.
 6. See, for example, Rozovsky, supra n. 2; Scott, Malpractice - The Legal Situation in Canadian Hospital Association Papers and Proceedings of the National Conference on Health and The Law 1 (1975); Geekie, supra n. 1; see also Haines, The Medical Professional and the Adversary Process (1973) 11 Osgoode L.J. 40.

The factors which have been identified can be roughly grouped as arising from the legal process,⁷ the insurance programs, the relationship between the legal and medical professions, and the attitudes and expectations of the public. Within the legal process there are great differences between Canada and the United States, ranging from the style of advocacy and use of the jury to the size of damage awards and the type of contingent fee used. The absence of national health insurance in the U.S.⁸ and the practices of the private insurance companies who cover doctors there are a striking contrast to our scheme of medicare and the Canadian Medical Protective Association. The style of practice and the interprofessional relations of doctors and lawyers are different in the United States.⁹ No doubt some of the antagonism is the consequence of the crisis, but the large number of professionals and the more business-like approach has led to a more competitive atmosphere wherein, for example, professional services are advertised and fees are paid directly by the patient. The constitutionally enshrined rights in the U.S. have no Canadian counterpart and no doubt

7. Some of the differences in the law itself such as that relating to informed consent, contributory negligence and res ipsa loquitur have been discussed.

8. Canada has been the subject of a study by the U.S., see Andreopoulos, National Health Insurance: Can We Learn From Canada? (1975).

9. Doctors are suing lawyers who sue them. See Foster v. McClain (1971) 250 So. 2d 179 (La. App.); Spencer v. Burglass (1974) 288 So. 2d, 68 (La. App.). A full page advertisement, Doctors Fight for Patients' Rights, Los Angeles Times, April 2, 1975, at 25 requested signatures on a petition restricting contingent fees. It was sponsored by a patients' rights group headed by two doctors. See also Louisell & Williams, Medical Malpractice, (1977) at 8.

this contributes to the difference between an American's and a Canadian's view of his "rights". Though the institutions of the two countries may diverge on these bases, there is some common ground; citizens of both countries seem to share a belief that there is breakdown in the doctor-patient relationship¹⁰ and they seem to hold an unreasonable expectation of what the health care system can deliver.

Reviewing the factors, and their presence in Canada, the cautious conclusion can be reached that Canada need not have a "crisis".

The Canadian Medical Protective Association is cautious too:¹¹

Although the number of legal actions against Association members rose sharply in the early years of this decade, 1970 through 1974, if the figures for recent years are adjusted to account for the increasing membership, the incidence of new suits each year has remained unchanged through 1975 and 1976. It might be hoped this indicates a trend about which there could be some cautious optimism.

The Report also notes another trend:¹²

The Statistical Review of the Association's work again this year discloses a continuing trend to which reference has been made in previous reports and which is of importance. Two hundred and eight-seven lawsuits started against Association members in earlier years were brought to a conclusion during 1976. Of this total, two hundred and sixteen ended without the payment of an award or settlement. Thus it can be said that seventy-five per cent of the actions concluded were probably lacking a sound legal basis. Each year, consistently, more than sixty per cent of the cases terminated are in this category and although no awards or settlements are paid, this group of lawsuits is costly to the Association in terms of legal expense, very little of which can ever be recovered from

10. Rozovsky, supra n. 2 at 6.

11. Report of General Counsel for the year 1977 in Canadian Medical Protective Association, Annual Report 1977 12.

12. Id. at 12-13.

the unsuccessful plaintiff. Why these actions are brought in the first instance is an interesting study in the "aetiology and pathogenesis" of medical malpractice litigation.

Change is clear from a statistical analysis set out by Geekie in the Canadian Medical Journal.¹³ As is evident from Table 1, the averages of awards and settlements doubled from 1975 to 1976 but decreased dramatically in 1978. Legal costs doubled from 1975 to 1978.

In 1978, one of every 87 Canadian doctor members was sued¹⁴ whereas approximately one of 10 is the most common figure given for the U.S. in recent years.

Canada need not and at present does not have a "malpractice crisis" but we must know more about the situation in Canada in order to make certain that it never occurs.

(b) An Alternative to Civil Litigation

Much criticism has been levelled against the present system where a patient must initiate and pursue a legal action against a doctor or hospital in order to obtain compensation for personal injuries.¹⁵ The lawsuit against a doctor or hospital is costly, slow, and complex.

13. Geekie, *supra* n. 1 at 34. Note that 1975-78 figures have been added based on the Annual Reports of the Canadian Medical Protective Association for those years.

14. Canadian Medical Protective Association represents "practically all" doctors. In 1978, 489 members were sued from a membership of 32,175. By contrast in 1977, 422 members were sued amongst 31,591 or 1 doctor of every 120. In 1976 it was approximately 1 in 134. Id.

TABLE 1

CMPA Receipts, Actions and Expenditures

Year	Dues \$	No. of writs served	Awards settlements \$	Legal Costs \$	Admin. Costs \$	Member- ship	Average of awards, settlements \$
1945	5	9	nil				
1950	5	11	11,700	6,216	3,608	3,367	---
			(4 settlements)	7,616	8,214	6,389	2,942.50
1955	20	11	54,864	21,056	27,263	8,983	4,572.00
			(3 awards and 9 settlements)				
1960	20	16	49,259	23,755	49,311	12,243	8,209.83
			(1 awards and 5 settlements)				
1965	15	49	168,119	67,553	93,134	15,940	11,207.93
			(3 awards and 12 settlements)				
1970	35	80	223,951	238,818	224,486	21,959	7,722.45
			(8 awards and 21 settlements)				
1971	35	131	276,292	251,924	218,988	23,668	8,634.13
			(10 awards and 22 settlements)				
1972	50	152	253,371	427,250	312,555	24,945	7,677.91
			(4 awards and 29 settlements)				
1973	50	168	325,087	441,662	310,685	26,588	9,561.38
			(2 awards and 32 settlements)				
1974	50	220	896,858	664,116	391,492	29,096	13,385.95
			(9 awards and 58 settlements)				
1975	100	229	951,609	776,916	487,282	30,022	18,300.17
			(9 awards and 43 settlements)				
1976	200	234	2,664,103	1,119,657	686,100	31,421	37,522.58
			(7 awards and 64 settlements)				
1977	250	269*	2,336,962	1,143,121	738,447	31,591	32,914.96
			(6 awards and 64 settlements)				
1978	250	323*	1,211,038	1,455,589	792,183	32,175	14,951.09
			(14 awards and 67 settlements)				

Note:

*422 members named in 269 writs

*489 members named in 323 writs

On the other hand it is still seen to serve useful purposes including the setting and maintaining of standards of medical care.¹⁶

The no-fault scheme has become the Cinderella sister of the tort action. There is a plethora of opinion¹⁷ on the topic in regard to motor vehicle accidents. No-fault schemes exist in Canada in for example, workers' compensation schemes and portions of automobile insurance plans. New Zealand has in place a plan that includes coverage for medical, surgical, dental or first-aid misadventure.¹⁸ But as the literature and experience referred to point out, no-fault schemes for medical accidents are, too, fraught with difficulties.¹⁹

Perhaps the time has come in Canada to look more closely at alternatives to the tort action for settling the compensation to injured patients. One possibility is a no-fault scheme.²⁰ Another is a combination of the tort action and a compensation plan,²¹ and yet

15. For an excellent analysis see Taylor, The Doctor and Negligence 141-144 (1971).

16. Kretzmer, The Malpractice Suit: Is It Needed? (1973) 11 Osgoode L.J. 55; Pritchard, Professional Civil Liability and Continuing Competence in Studies in Canadian Tort Law 377 (1977); see also Linden, The Negligent Doctor (1973) 11 Osgoode L.J. 31 at 39.

17. For a thorough discussion with references to many other research sources see Linden, Canadian Tort Law 511-543 (1973). See also, Saunders, ed., The Future of Personal Injury Compensation (1978).

18. Woodhouse, Compensation for Personal Injury in New Zealand in Report of the Royal Commission (1967).

19. Ehrenzweig, Compulsory "Hospital-Accident" Insurance: A Needed First Step Toward the Displacement of Liability for Medical Malpractice (1964) 31 U. Chi. L. Rev. 279.

20. See Haines, supra n. 11 at 52.

21. See Kretzmer, supra n. 22 at 79.

another an arbitration procedure.

There is a great volume of material to assist in such a study. Very recently two Canadian authors, Sharpe and Sawyer²² reviewed some of the alternatives from the perspectives of doctors and patients. More analyses like this must be commenced.

While it is not within the ambit of this thesis to examine this topic in depth, one observation and one recommendation must be made. The observation is that all of the alternate schemes advanced have as potential weaknesses those pointed out in the present system. As a distinguished Alberta judge, Mr. Justice Laycraft, said:²³

This [a no-fault scheme] simply envisages the development of another court; only the name is changed.

The recommendation is that while studying the alternatives to it we must continue to use our best efforts to improve the civil litigation system so that it is made as fair as it can be to patients and doctors and hospitals.

2. Suggestions for the Future

As a result of my research certain recommendations seem apparent:

22. Sharpe and Sawyer, Doctors and the Law (1978).

23. Saunders, ed., The Future of Personal Injury Compensation (1978) 22.

(i) We must find and develop our own law. Excellent Canadian legislation and case law does exist and could assist in dealing with current and recurrent medical-legal problems, but it appears that it is not always found. The research done by lawyers in preparing cases could be improved. On some topics such as consent there is Canadian jurisprudence much more appropriate to our society than that being transplanted from, for example, the United States. Furthermore, we should resist any move to develop a sub-category of legal principals unique to medical legal issues. For example, the characteristics of the tort of battery and the defence of consent should be the same whether the fact situation is "touching" by a doctor or by an assailant. The basic right being protected is the same in either case.

We need more and better judgments to settle medical-legal issues and make the law more predictable. In the past the Supreme Court of Canada has heard very few cases in this area and those decisions sometimes failed to clarify important issues.²⁴

There are some excellent recommendations for the reform of federal and provincial legislation and for new legislation. But politicians must act responsibly in bringing forward legislation that is needed.

(ii) We must have more data on issues of concern. More statistics are required on the liability of doctors and hospitals in Canada. An example of the type of research necessary is that done by the Institute of Comparative Law at McGill University wherein all suits brought against doctors and hospitals in Quebec for the period, January 1st,

24. Weiler, Groping Towards A Canadian Tort Law: The Role of the Supreme Court of Canada (1971) 21 U.T.L.J. 267.

1968 to December 31st, 1977 have been exhaustively analyzed.²⁵

More empirical studies on attitudes and practice are necessary. Credit should be given to the Sunnybrook Health Attitude Survey²⁶ which showed, among other things, that while 86% of the patients surveyed believed that "doctors did a good job"²⁷, most patients were greatly misinformed about health care benefits and costs.²⁸ The survey done by lawyers Shapre and Gray²⁹ showed that over 90% of Ontario doctors would stop to help an injured person whereas two polls of U.S. physicians found that 50% of those who answered said they would stop. (The reason given for failing to stop was the same in both surveys: fear of a negligence action.)³⁰ These studies have revealed some significant facts, but much more must be known before meaningful conclusions can be drawn.

(iii) We must enter into and foster new relationships and associations. Too much emphasis has been placed on the differences between doctors and lawyers. Given the common goal of providing the best

25. Centre de Droit Privé et Comparé McGill University, Interpretation de Certaines Données Relatives Aux Accidents Latrogeniques (1978).

26. Le Riche et al. eds., People Look At Doctors: The Sunnybrook Health Attitude Survey (1971).

27. Id. at 102.

28. Id. at 103.

29. Gray and Sharpe, Doctors, Samaritans and the Accident Victim (1973) 11 Osgoode L.J. 1. Another Ontario study is reported in (1970) 3 Report of the Ontario Committee on the Healing Arts 71.

30. For the reasonableness of this fear see supra Chapter 5.

possible life style for each member of our society these differences pale. Numerous examples exist of the two professions working well together and in conjunction with other health care professionals: medical-legal societies in many Canadian cities, the National Conferences on Health and the Law in 1975 and 1979 sponsored by the Canadian Hospital Association, participation of noted Canadian authorities in meetings and seminars. New groups should be formed in areas of common and special interest: forensic medicine, sports medicine, and psychiatry are obvious examples. The publications of each profession should expand their terms of reference and invite more contributions from others.

No doubt more needs to be done to encourage association amongst those in the health care professions too. A recent successful seminar saw nurses, dieticians and physicians meet to study their problems and the law. Lectures and seminars to all health care professions serving in a hospital can be most effective. The old fear that each professional will be unresponsive in the company of others is not valid.

However, an advancement in the relationships among those mentioned above leaves a void unless the patient is considered. It seems trite to say that the patient is the raison d'être of the health care system, but this fact seems to be forgotten. Associations of citizens or patients must be part of the search for information and solutions. They should not be feared but fostered. Lawyers, doctors and other health care professionals should be prepared to work with them and to join them.

(iv) We must work to improve the legal process. Steps have been taken to try to expedite litigation to meet the criticism of slowness

and to extend legal aid coverage to answer the cry that it is too costly. Hopefully more will be done. Systems to allow patients better access to doctors who will assess their claims and, if necessary, testify must be tested and strengthened. If the adversary system is to work properly patient's lawyers must become more specialized and perhaps share expertise.

More information about the law and the legal process should reach students in medicine and other health care professions. A few faculties and schools make it part of their curricula. Innovative approaches such as moots on health care topics work very well. Many concerns could be alleviated if time was made for the legal education of health care professionals.

(v) We must communicate. When we fail to realize and utilize opportunities to communicate we create our own problems. A review of Canadian cases against doctors and hospitals illustrates that in most cases there was a breakdown in communication with the patient. This should serve as a warning to lawyers about their relationships with clients, doctors and other health care professionals. Misunderstanding and hostility grow out of ignorance.

Communication might mean the doctor speaking to the patient the night before surgery, or after the risk has materialized, but it could also mean determining with a colleague who will take responsibility for reading the test results of a common patient.

Communication could also mean the lawyer going to the doctor's office to discuss the medical-legal report and to prepare him to be examined on his qualifications.

Communication should mean the doctor and lawyer being prepared to participate in lectures to students and talks to patients' groups.

Communcation alone, however, may not be enough without good will and the sense that to be a professional means to serve the needs of society.

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